FILED
SEP 17 2004
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No. 04 432

In The
Supreme Court of the United States

PHYSICIANS MULTISPECIALTY GROUP,
Petitioner,

v.

THE HEALTH CARE PLAN OF HORTON HOMES, INC.; HORTON HOMES, INC.,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

The following question is presented by the Petition for Writ of Certiorari:

Should this honorable Court address the issue of a medical provider's standing to assert a cause of action pursuant to E.R.I.S.A. 29 U.S.C. § 1132(a)(1)(B)? The United States Court of Appeals for the Eleventh Circuit held that Physicians Multispecialty Group, a medical provider, lacked standing to pursue a claim for benefits pursuant to E.R.I.S.A. 29 U.S.C. § 1132(a)(1)(B). The Eleventh Circuit's decision conflicts with other of the circuit courts of appeal.

LIST OF ALL PARTIES TO THE PROCEEDING

1. *Petitioner*

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Augusta, GA 30909

2. *Appellate Court*

The United States Court of Appeals for the Eleventh Circuit
56 Forsyth Street, N.W.
Atlanta, GA 30303

3. *Trial Judge*

Honorable Chief Judge Dudley H. Bowen, Jr.
U.S. District Court for the Southern District of Georgia
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7. ***The Health Care Plan of Horton Homes, Inc.***

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Supreme Court Rule 29.6, Petitioner identifies Physicians Multispecialty Group as a Georgia Professional Corporation. There is no parent corporation and none of the stock is owned by a publicly held corporation.

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PETITION FOR WRIT OF CERTIORARI

To the honorable, the Chief Justice and Associate Justices of the Supreme Court of the United States:

Physicians Multispecialty Group (hereinafter "PMG"), petitioner herein, respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Eleventh Circuit, reproduced in the Appendix, herein, at pages 001 - 007, and affirmed by a denial of a petition to grant rehearing or hearing *en banc*, reproduced in the Appendix, herein, at page 025.

OPINIONS BELOW

The opinion of the United States District Court for the North District of Georgia at Macon, Case Number 02-00102-CV-DHB-1 is unreported and reproduced in the Appendix, herein, at pages 008 - 024. Subsequent to issuance of the district court opinion, the health care plan of Horton Homes, Inc. (hereinafter "the plan") appealed to the United States Court of Appeals for the Eleventh Circuit which, on June 3, 2004, reversed and held that PMG had no standing to assert a cause of action pursuant to E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B). PMG timely moved for a rehearing or, alternatively, for an *en banc* hearing on June 15, 2004, and the petition was denied on July 23, 2004.

JURISDICTION

This Court has jurisdiction pursuant to 29 U.S.C. § 1132(e) and 28 U.S.C. § 1254.

STATUTORY PROVISIONS INVOLVED

The following statutory provisions are at issue and reproduced in the appendix herein:

1. 29 U.S.C.S. § 1132(a)(1)(B) provides, in pertinent part:

> "(a) **Persons empowered to bring a civil action.** A civil action may be brought –
>
> (1) by a participant or beneficiary –
>
> • • •
>
> (B) to recover benefits due him under the terms of his plan, . . ." (Emphasis added; App. 026)

2. 29 U.S.C.S. § 1002(8) states, in pertinent part, that: a "beneficiary" is "a person designated . . . by the terms of an employee benefit plan who is or may become entitled to a benefit thereunder." (Emphasis added; App. 032)

3. 29 U.S.C.S. § 1056 which states, in pertinent part,

> "(d) Assignment or alienation of plan benefits.
>
> (1) Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated." (App. 034)

STATEMENT OF THE CASE

PMG is a physicians group practicing in Augusta, Georgia.

Horton Homes is a corporation which does business in Georgia. Horton Homes established an E.R.I.S.A. governed health benefits plan (i.e., the plan) for its' employees and their dependents. Horton Homes is the plan administrator, employer, sponsor and funder of the plan. (App. 039)

On September 27, 1999, Linton Franklin enrolled his minor child, Candace Murray, in the plan as a "dependent child". (App. 040)

Unfortunately, seventeen year old Candace Murray passed on July 21, 2002 after a brief illness. (App. 041) Amongst over $1,000,000.00 in medical bills incurred to treat Ms. Murray were $68,230.00 for services rendered by PMG. (App. 042, 043)

After receiving the medical bills Horton Homes took the position, for the first time, that Candace Murray:

> "was not an eligible dependent child of Linton Franklin . . . . Therefore, Candace Murray was not eligible for coverage under the plan. As a result, your claim is excluded from coverage". (App. 044)

PMG holds an assignment of benefits executed by Candace Murray's estate. (App. 045)

PMG sued the plan pursuant to E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B) asserting a claim for benefits for the treatment rendered Candace Murray. The district court ruled with PMG and awarded it benefits. The Eleventh Circuit reversed and held that PMG had no standing to assert a claim pursuant to E.R.I.S.A.

The plan document states, in pertinent part, as follows:

> **Amounts payable at any time may be used to make direct payments to health care providers.** Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to . . . assignment, ... Any attempt to . . . assign, . . . any such amount, whether presently or hereafter payable, shall be void. (App. 046)

The plan also provides a definition of "beneficiary" as follows:

> The term *beneficiary* means the person or persons named to receive plan benefits. For all benefits, the beneficiary is the participant except **if such benefits are assigned to a health care provider**. (App. 047)

The Eleventh Circuit held that PMG did not have derivative standing because of the anti-assignment provision cited above.

PMG would fully concur with any decision of any court which blocked a healthcare provider's derivative

standing where an E.R.I.S.A. governed plan unambiguously precluded assignment of benefits to a healthcare provider and where the provider did not otherwise have independent standing to sue. However, the foregoing scenario is not now before this court. The issue in the matter *sub judice* is not really whether PMG has derivative standing as an assignee. **Instead, PMG respectfully asserts that the relevant issue is whether PMG is a "beneficiary" as defined by E.R.I.S.A. 29 U.S.C.S. § 1002(8) and the plan so as to have independent standing to bring suit pursuant to 29 U.S.C.S. § 1132(a)(1)(B).**

Under E.R.I.S.A., a "beneficiary" can maintain an action for benefits. (29 U.S.C.S. § 1132(a)(1)(B)) Several circuit courts have held that a healthcare provider generally does not have independent standing to sue under E.R.I.S.A., but that a provider holding an assignment can maintain a derivative action. (See *Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997)) The court stated in *Cagle*, "The list in § 1132(a) limits those parties who have independent standing (as opposed to derivative standing) to sue an E.R.I.S.A. plan." (Emphasis added; *Cagle*, 112 F.3d 1510, 1514 citing *Hermann Hosp. v. MEBA Medical and Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988).)

PMG did not argue to the lower courts that it only had derivative standing to bring an action. Instead, PMG consistently argued that it was a "beneficiary" under the specific terms of the plan document and, therefore, per the definition of "beneficiary" at E.R.I.S.A. 29 U.S.C. § 1002(8) so as to have independent standing to bring an action.

There is a peculiar plan term in the matter *sub judice* which provides PMG independent standing and which the Eleventh Circuit panel failed to even mention in its' opinion. The panel's entire opinion is based upon the finding that the plan document has an "unambiguous anti-assignability provision". (App. 006) However, the panel failed to address a plan term that is absolutely critical to PMG's independent standing.

The plan has a specific and unequivocal definition of the term "beneficiary". The plan states:

> The term *beneficiary* means the person or persons named to receive plan benefits. For all benefits, the beneficiary is the participant except if such benefits are assigned to a health care provider. (Emphasis added; App. 047)[1]

E.R.I.S.A. provides that a "beneficiary" is a person or entity designated by "the terms of . . . (the) plan." (29 U.S.C. § 1002(8)) The plan under which PMG seeks benefits specifically defines a "beneficiary" as "the participant except if such benefits are assigned to a health care provider." (*Id.*) Clearly, PMG is a defined "beneficiary" under the plans' terms and, therefore, is a "beneficiary" per E.RI.S.A. 29 U.S.C.S. § 1002(8).

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[1] The plan document clearly contemplates payment of benefits directly to healthcare providers when it states specifically prior to the anti-assignment provision relied upon by the panel that "amounts payable at any time may be used to make direct payments to healthcare providers". (App. 046)

The Eleventh Circuit failed to take into consideration the specific definition of "beneficiary" in the plan document and failed to consider whether PMG was a "beneficiary" which was independently entitled to bring suit. No prior case of this court has held that a medical provider does not have an independent right to bring suit when that provider is a "beneficiary" as defined in the E.R.I.S.A. governed benefit plan.

The panel stated that the matter *sub judice* presented a matter of first impression for the Eleventh Circuit. (App. 004) PMG respectfully agrees, but the issue is not really whether a medical provider is prohibited by an anti-assignment provision from asserting derivative entitlement to benefits as the panel asserts. [2] (*Id.*)

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[2] PMG also respectfully disagrees with the panel's conclusion that the anti-assignment provision is unambiguous. The panel opinion never mentions the above plan term providing for direct payment to medical providers or the plan definition of "beneficiary". When the plan document is read as a whole it is clear that the plan contemplates payment directly to medical providers. The reason the plan contemplates payment directly to medical providers is because of the specific definition of "beneficiary". Clearly, if a medical provider has a valid assignment then the medical provider is a defined "beneficiary" under the plan and would be entitled to payment directly thereunder in its' own right. The most logical interpretation of the anti-assignment provision is that it applies to anyone who is not a defined "beneficiary". Under such an interpretation, the anti-assignment provision would block assignments to all but medical providers. Therefore, a plan participant could not assign benefits to the local pawnshop, for example. However, the plan clearly contemplates that a medical provider with an assignment is a "beneficiary" with independent standing to pursue benefits. When considering the whole of the plans terms the anti-assignability provision is not "unambiguous" as the panel asserts.

Instead, the issue of first impression for the Eleventh Circuit is whether a medical provider can have independent standing to bring a an E.R.I.S.A. claim where the plan document has a specific definition of "beneficiary" which includes "a medical provider" to whom benefits have been assigned.

The issues raised herein are of paramount public importance. Clearly, there are hundreds of thousands of medical providers, millions of plan participants and thousands of E.R.I.S.A. plans in the United States. If the Eleventh Circuit is going to establish binding precedent that is going to very much effect the dealings between the above referenced parties, at least in the Eleventh Circuit, then such precedent should be thoroughly considered, well reasoned and consistent with the decisions of this Court and the other federal appellate courts.

REASONS FOR GRANTING CERTIORARI

The Eleventh Circuit's decision conflicts with other Circuit Court of Appeals' decisions on the important issue of a medical providers' standing to assert a claim for benefits pursuant to E.R.I.S.A. PMG believes that the Eleventh Circuit's decision was flawed in its' legal analysis, but whether the decision was legally sound or not, it conflicts with decisions from other federal circuit courts applying E.R.I.S.A. and this Court's decisions to the same or very similar facts.

The sole issue raised herein is what standing, if any, does a medical provider have to assert a claim for benefits pursuant to E.R.I.S.A. against a health benefits

plan. The Eleventh Circuit and other circuit courts have stated that, the issue of whether a health care provider can directly maintain an action against an E.R.I.S.A. governed benefits plan is a question of great public importance.

> "If provider-assignees cannot sue the E.R.I.S.A. plan for payment, they will bill the participant or beneficiary directly for the insured medical bills, and the participant or beneficiary will be required to bring suit against the benefit plan when claims go unpaid . . . On the other hand, if provider-assignees can sue for payment of benefits, an assignment will transfer the burden of bringing suit from plan participants and beneficiaries to "providers (who) are better situated and financed to pursue an action for benefits owed for their services." . . . For these reasons, the interest of E.R.I.S.A. plan participants and beneficiaries are better served by allowing provider-assignees to sue E.R.I.S.A. plans." *Cagle v. Bruner*, 112 F.3d 1510, 1515 (11th Cir. 1997), citing *Hermann Hosp. v. MEBA Medical and Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988).

Despite the fact that certain courts have recognized that the relevant issue is one of vast public importance, the circuit courts' holdings are inconsistent. The broad issue of a health care providers standing to bring suit pursuant to E.R.I.S.A. § 1132(a)(1)(B) involves three distinct sub-issues.

1. The first sub-issue is whether or not a medical provider can have independent standing to pursue a claim for benefits per the language of E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B).

2. The second sub-issue is whether a medical provider who holds a valid assignment from a plan participant has derivative standing, if not independent, to assert a cause of action pursuant to E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B).

3. The third sub-issue is whether a medical provider with a valid assignment can pursue a claim for benefits via derivative standing if the plan has an anti-assignment provision.[3]

Various of the federal circuit courts have held about every way possible regarding the foregoing three sub-issues. The matter *sub judice* presents a perfect opportunity for this honorable Court to address each of the foregoing three sub-issues and to provide definitive direction on the important issue of a medical providers' standing to sue an E.R.I.S.A. health plan and, so as to resolve the discrepancies amongst the various circuit courts' holdings on the issue.

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[3] There is a fourth sub-issue that will not be discussed herein and that is whether a medical provider has a right to assert state law claims or whether those claims are preempted by E.R.I.S.A. 29 U.S.C.S. § 1144. Some courts have held that the medical providers' state law claims are not preempted by E.R.I.S.A. (See *Lordman v. Equicor, Inc.*, 32 F.3d 1529 (11th Cir. 1994.) Other circuit courts have held that a medical providers' state law claims are preempted by E.R.I.S.A. (See *HealthSouth Rehabilitation Hospital v. American Red Cross*, 101 F.3d 1005 (4th Cir. 1996).)

Sub-Issue 1.

Can a medical provider have independent standing to assert a claim for benefits pursuant to E.R.I.S.A.? The Eleventh Circuit has held that a medical provider does not have independent standing to assert a cause of action pursuant to E.R.I.S.A. (See *Cagle*, 112 F.3d 1510, 1515, citing *Herman Hospital*, 845 F.2d 1286, 1289.) However, the Seventh Circuit has held that in some circumstances a medical provider holding an assignment may assert a cause of action as a "beneficiary", thereby, having independent standing for the purpose of E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B) and 29 U.S.C.S. § 1002(8). The Seventh Circuit recognized the discrepancies between the various circuit courts' decisions and stated:

> "Three courts of appeals have taken three approaches to the question of whether an assignee may sue. *Northeast Department ILGWU Health & Welfare Fund v. Teamsters Local No. 229 Welfare Fund*, 764 F.2d 147, 153-54 & n.6 (3d Cir. 1985), holdings that the statutory list is exclusive, and that because Congress did not mention assignees, they may not sue on the authority of § 1132(a)(1)(B). On different theories, the judges went on to hold that an effort to enforce ERISA's substantive rules states a claim under federal common law, for which 28 U.S.C. § 1331 supplies jurisdiction. *Misic v. Building Service Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986), treating the question as one of "standing", concluded that assignees may stand in the shoes of

beneficiaries. It relied on *United States v. Carter*, 353 U.S. 210, 1 L. Ed. 2d 776, 77 S. Ct. 793 (1957), which resolved in favor of jurisdiction a similar question under the Miller Act, 40 U.S.C. § 270a. *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286, 1289-90 (5th Cir. 1988), agrees with *Misic* that an assignee has standing -- it has a personal stake in the outcome -- but adds that the plaintiff must be an authorized claim-holder under both ERISA and the contract. *Hermann* holds that ERISA permits the transfer, for the anti-assignment clause governing pension benefits, 29 U.S.C. § 1056(d)(1), does not apply to welfare benefits. Contractual rights were obscure, and the fifth circuit remanded so that the district judge could explore the validity of the assignment.

As we see things, a combination of statutory text and *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989), shows that § 1132(a)(1)(B) supplies jurisdiction when a provider of medical services sues as assignee of a participant. **ERISA defines a "beneficiary" as "a person designed by a participant . . . who is or may become entitled to a benefit" under the plan. 29 U.S.C. § 1002(8). Myers, unquestionably a "participant" as § 1002(7) uses that term, designated Kennedy as the person to receive her benefits. That makes Kennedy a "beneficiary".** To the extent doubt remains, *Firestone* tells us to treat as a "participant" for jurisdictional purposes anyone with a colorable claim to benefits, 489 U.S. at

117-18, an approach equally applicable when a person claiming to be a "beneficiary" files suit. Kennedy has a colorable claim. Because ERISA instructs courts to enforce strictly the terms of plans, see 29 U.S.C. § 1104(a)(1)(D) and *Central States Pension Fund v. Gerber Truck Service, Inc.*, 870 F.2d 1148 (7th Cir. 1989) (in banc), an assignee cannot *collect* unless he establishes that the assignment comports with the plan. But as *Firestone* held, subject-matter jurisdiction depends on an arguable claim, not on success. See also *Sisters of the Third Order of St. Francis v. SwedishAmerican Group Health Benefit Trust*, 901 F.2d 1369, 1370 (7th Cir. 1990). Only if the language of the plan is so clear that any claim as an assignee must be frivolous is jurisdiction lacking. *Bell v. Hood*, 327 U.S. 678, 90 L. Ed. 2d 939, 66 S. Ct. 773 (1946); *Goosby v. Osser*, 409 U.S. 512, 518, 93 S. Ct. 854, 858, 35 L. Ed. 2d 36 (1973). Kennedy's claim is colorable. Section 20 of CIGNA's policy provides that "medical benefits are payable to the Employee. However, at the option of the Insurance Company and with the consent of the Policyholder, all or any part of the medical benefits may be paid directly to the person or institution on whose charge the claim is based." **The possibility of direct payment is enough to establish subject-matter jurisdiction. Whether CIGNA properly withheld assent to the transfer goes to the merits rather than jurisdiction.**" (Emphasis added; *Kennedy v. Connecticut General Life Insurance Co.*, 924 F.2d 698, 700, 701 (7th Cir. 1991).)

It has always been PMG's position that it has independent standing as a plan defined "beneficiary" to assert a cause of action pursuant to 29 U.S.C.S. § 1132(a)(1)(B). The Eleventh Circuit did not address PMG's argument regarding its' "independent standing". Instead, the Eleventh Circuit addressed the matter of PMG's standing as if PMG was only asserting derivative standing. In the matter *sub judice*, the Eleventh Circuit panel clearly intended to supplement *Cagle* by addressing the issue of derivative standing in the face of an anti-assignment provision despite the fact that PMG had always argued that it had "independent" standing.[4]

As the Seventh Circuit held in *Kennedy* a person other than the plan participant can be a "beneficiary" for the purpose of E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B) and the Eleventh Circuit's failure to recognize PMG's independent standing is contrary to *Kennedy*.

Sub-Issue 2.

Despite PMG's assertion that it has "independent" standing, the panel addressed the issue of PMG's standing as if PMG was asserting only derivative standing. About half of the circuit courts have addressed the issue of whether non-enumerated party under 29 U.S.C. § 1132(a)(1)(B) holding a valid assignment from an enumerated party, such as a plan participant, can assert a derivative cause of action

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[4] In *Cagle*, the Eleventh Circuit noted that it was not, in that opinion, addressing the "issue of whether a provider-assignee can sue an E.R.I.S.A. plan, where the terms of the plan forbid such an assignment". *Cagle*, 112 F.3d 1510, 1516, fn3.

pursuant to E.R.I.S.A. Most of the circuit courts have based their holdings upon *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 100 L. Ed. 2d 836, 108 S. Ct. 2182 (1988). In *Mackey*, this honorable Court held that:

> "While Congress prohibited the assignment or alienation of benefits under pension plans, 29 U.S.C. § 1056(d)(1), Congress did not include such a ban on the assignment of benefits under welfare plans, and reasoned that "Congress' decision to remain silent concerning the attachment or garnishment of E.R.I.S.A. welfare plan benefits acknowledged and accepted the practice, rather than prohibiting it." *City of Hope National Medical Center v. Healthplus, Inc.*, 156 F.3d 223 (1st Cir. 1998) citing *Mackey*, 486 U.S. 825, 837-838 (quoting *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 516, 68 L.Ed.2d 402, 101 S.Ct. 1895 (1981)).

Several federal circuit courts have held, based upon *Mackey*, that a medical provider holding a valid assignment from a qualified plan participant does have derivative standing to assert a cause of action pursuant to E.R.I.S.A. As the Eleventh Circuit stated in *Cagle*, recognizing the derivative standing of a medical provider,

> "The Fifth, Seventh, Eighth, and Ninth Circuits have held that an assignee of ERISA-covered medical benefits has derivative standing to bring an action under § 1132(a) against an ERISA plan, if the plan does not forbid assignments of

> benefits. *Cagle*, 112 F.3d 1510, 1515 (11th Cir. 1997); *Hermann*, 845 F.2d at 1289; *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 700-01 (7th Cir. 1991); *Lutheran Med. Ctr. V. Contractors Health Plan*, 25 F.3d 616, 619 (8th Cir. 1994); *Misic v. Building Serv. Employees Health and Welfare Trust*, 789 F.2d 1374, 1379 (9th Cir. 1986).[5]

According to the Fifth, Seventh, Eighth, and Ninth Federal Circuit Courts, "§ 1132(a) does not preclude assignees from enforcing rights assigned by them by those listed in the statute of permissible plaintiffs." *Cagle*, 112 F.3d 1510, 1515.

However, at least one federal circuit court has held that the list of enumerated persons who can bring a claim for benefits pursuant to E.R.I.S.A. is exhaustive and that no assignee of such person can bring a claim for benefits under E.R.I.S.A. In *Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147 (3rd Cir. 1985), the court specifically held:

> "we hold that the express jurisdictional provisions of ERISA, found in 29 U.S.C. § 1132, do not authorize federal jurisdiction over a suit, such as the one at bar, brought by a pension

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[5] The Second Circuit has similarly held. See *I.V. Services of America, Inc. v. Trustees of the American Consulting Engineers Council Insurance Trust Fund*, 136 F.3d 114 (2nd Cir. 1998). Although the Second Circuit has also held that it does not recognize derivative standing to assert an E.R.I.S.A. claim. (See *Tuvia Convalescent Center, Inc. v. National Union of Hospital and Healthcare Employees*, 717 F.2d 726 (2nd Cir. 1983).)

fund and its' trustee against another pension fund. n6.

n6 Judge Fullam's conclusion -- that there is jurisdiction in this case under 29 U.S.C. § 1132(a)(1)(B) because the ILGWU Fund is the "assignee or subrogee" of Mrs. Fazio, *see infra*, typescript at (Fullam J., concurring) -- is appealing because of its simplicity, but we find ourselves unable to subscribe to it on several grounds. First, Congress simply made no provision in § 1132(a)(1)(B) for persons other than participants and beneficiaries to sue, including persons purporting to sue on their behalf. Second, the intentions of the parties and the district court regarding federal jurisdiction are irrelevant to the determination whether such jurisdiction exists. Third, Mrs. Fazio did not, in fact, make an assignment of her claim to the ILGWU fund, and it is far from clear that, in litigating this case, the ILGWU Fund pursued only Mrs. Fazio's rights and not also its own interests. Moreover, even if Mrs. Fazio had actually assigned her claim to the ILGWU Fund, we have serious doubts whether she could assign along with her substantive rights her right to sue in federal court." *Northeast*, 764 F.2d 147, 154 (3rd Cir. 1985).

Some federal circuit courts have not specifically addressed the issue of derivative standing. However, amongst those circuit courts which have addressed derivative standing to sue under E.R.I.S.A., there is a split of authority.

Sub-Issue 3.

As stated above, it has always been PMG's position that it has "independent" standing, but it is the third sub-issue that the Eleventh Circuit panel focused upon in the matter *sub judice*. The Eleventh Circuit held that PMG did not have derivative standing despite PMG's assignment because the panel found that the plan had an unambiguous anti-assignability provision. The panel's opinion stated:

> "Considering this issue, we are persuaded by the reasoning of the majority of federal courts that have concluded that an assignment is ineffectual if the plan contains an unambiguous anti-assignment provision. *See, e.g., City of Hope Nat'l Med. Ctr. V. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) ("Consistent with the other circuits which have addressed this issue, we hold that ERISA leaves the assignability or non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties."); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1464-65 (10th Cir. 1995) ("ERISA's silence on the issue of the assignability of insurance benefits leaves the matter to the agreement of the contracting parties."); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991) ("As a general rule of law, where the parties' intent is clear, courts will enforce non-assignment provisions."); *Washington Hosp. Ctr. Corp. v. Group Hospitalization and Med. Servs., Inc.*, 758 F.

Supp. 750, 755 (D.D.C. 1991) (holding that an anti-assignment provision was valid and enforceable after concluding that enforcement of the provision was not contrary to public policy); *see also, e.g., Neurological Res., P.C. v. Anthem Ins. Cos.*, 61 F. Supp. 2d 840, 845-46 (S.D. Ind. 1999); *Renfrew Ctr. v. Blue Cross & Blue Shield of Cent. N.Y., Inc.*, No. 94-CV-1527, 1997 WL 204309, at *3-4 (N.D.N.Y. Apr. 10, 1997); *Home Nutritional Servs., Inc. v. Blue Cross & Blue Shield of Mass., Inc.*, Nos. 93-CV-10211-Z, 93-CV-10658-Z, 1993 WL 343674, at *1-2 (D. Mass. Aug. 24, 1993); *Parkside Lutheran Hosp. R.J. Zeltner & Assocs., Inc.*, 788 F. Supp. 1002, 1004-05 (N.D. Ill. 1992).

In deciding that an unambiguous anti-assignment provision in an ERISA-governed plan voids any purposed assignment, the Ninth Circuit began by noting that any construction of ERISA must be consistent with Congressional intent. *Davidowitz*, 946 F.2d at 1480. "Even if it could be said that required assignability promotes certain ERISA policies, this Court would not create a construction requiring assignability in the face of Congressional silence on the issue." *Id. See also St. Francis Reg'l Med. Ctr.*, 49 F.3d at 1465.

The *Davidowitz* court further noted that the Supreme Court has stated that Congress carefully considered assignment of both pension and welfare benefit plans and consciously decided to prohibit assignment of pension plans but remained silent on the assignment of welfare

benefit plans. *See Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 837, 108 S. Ct. 2182, 2189, 100 L. Ed. 2d 836 (1988) ("[Congress] had before it a provision to bar the alienation or garnishment to ERISA plan benefits, and chose to impose that limitation only with respect to ERISA pension benefit plans, and *not* ERISA welfare benefit plans. In a comprehensive regulatory scheme like ERISA, such omissions are significant ones."). In sum, the *Davidowitz* court found that it could not agree that Congressional silence on the issue shows a Congressional intent to mandate assignability. "On the contrary, if Congress had intended this result, it could have said so." *Davidowitz*, 946 F.2d at 1480. The court concluded that Congress "intended instead to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve." *Id.* at 1481.

We agree with *Davidowitz* and *St. Francis Reg'l Med. Ctr.* that Congressional silence on the issue does not mandate a Congressional intent to mandate assignability. Because ERISA-governed plans are contracts, the parties are free to bargain for certain provisions in the plan – like assignability. Thus, an unambiguous anti-assignment provision in an ERISA-governed welfare benefit plan is valid and enforceable.

Having determined that an unambiguous anti-assignability provision in an ERISA-governed

> welfare benefit plan voids any purposed assignment, we must consider whether the anti-assignability provision in this Plan is unambiguous. We conclude that it is. The provision states in clear terms that "[e}xcept as applicable law may otherwise require, no amount payable at any time . . . shall be subject in any manner to alienation by . . . assignment . . . of any kind[]." By its own terms, the provision clearly and unambiguously prohibits Murray from assigning benefits to PMG. Accordingly, the anti-assignment clause precludes PMS's maintenance of an ERISA action." (App. 005, 006, 007)[6]

However, other federal courts of appeal have allowed medical providers to pursue a claim for benefits pursuant to E.R.I.S.A. via derivative standing even in the face of an anti-assignment provision in the plan. If PMG does not have "independent" standing as it believes and if the issue and facts truly are as the panel of the Eleventh Circuit held then the issue of PMGs' standing is analogous to two circuit court holdings where a medical provider was allowed to pursue a claim via derivative standing despite an anti-assignment provision.

The Fifth Circuit Court of Appeals has held on at least two occasions that a medical provider could pursue a claim via derivative standing despite a plan's anti-assignment provision. In *Hermann Hospital v.*

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[6] Again, PMG very much disputes that the anti-assignment provision in the plan "clearly and unambiguously" prevents assignment to medical providers. (See fn 2 herein)

MEBA Medical and Benefits Plan, 959 F.2d 569 (5th Cir. 1992) (commonly known as *Hermann II*), the plan provided an anti-assignment provision as follows:

> "No employee, dependent or beneficiary shall have the right to assign, . . . any benefit payment hereunder, and any such payment shall not be subject to any legal process to levy execution upon or attachment or garnishment proceedings against for the payment of any claims." (*Hermann*, 959 F.2d 569, 574)

The *Hermann II* anti-assignment provision is nearly identical to the provision in the matter *sub judice* except that the *Hermann II* term is not prefaced by the statement "amounts payable at any time may be used to make direct payments to health care providers" as in the case of the plan from which PMG seeks benefits. (App. 046))

Despite the plan's anti-assignment provision, the Fifth Circuit allowed the medical provider in *Hermann II* to proceed via "derivative standing" stating:

> "We interpret the anti-assignment clause as applying only to unrelated, third-party assignees -- other than the health care provider of assigned benefits -- such as creditors who might attempt to obtain voluntary assignments to cover debts having no nexus with the Plan or its benefits, or even involuntary alienations such as attempting to garnish payments for plan benefits. The typical "spendthrift" language of the clause is clearly intended to prevent either

> voluntary or involuntary assignment of payments under the Plan to those creditors of the participant or beneficiary of the Plan which have no relationship to the providing of covered benefits. The anti-assignment clause should not be applicable, however, to an assignee who, as here, is the provider of the very services which the plan is maintained to furnish. Were we to conclude otherwise, health care providers such as Hermann, which is entitled to payment for the services it provided as benefits covered under the Plan, would be unable to recover for those services unless Mr. Nicholas were to sue MEBA for recovery of benefits and Hermann in turn sue Mr. Nicholas. Such a result would be inequitable as Nicholas, knowing that any recovery from MEBA would immediately go to Hermann, would have no incentive to pursue payment -- and might be reluctant to sue the Plan maintained by his own employer or his own union. Thus, the anti-assignment clause, even if timely asserted, would likely not have prevented Mrs. Nicholas from assigning to Hermann the right to payment for benefits it furnished as the provider of the health care services covered under the Plan." (*Hermann*, 959 F.2d 569, 575)

In 2002, the Fifth Circuit again allowed a medical provider to proceed via derivative standing despite an anti-assignment provision. (See *Dallas County Hospital District v. Associates Health and Welfare Plan*, 293 F.3d 282 (5th Cir. 2002).) In *Dallas County Hospital*, the court noted that the plan's anti-assignment provision seemed

to "carve out" an exception that assignments could be made to "network providers".

As stated several times in this petition, PMG believes that it has "independent" standing as a plan defined "beneficiary". However, if PMG does not have "independent" standing to assert a cause of action pursuant to E.R.I.S.A. then, at the very least, PMG respectfully asserts that the specific language of the plan at issue contemplates that the anti-assignment provision does not apply to medical providers holding an assignment. If the plan's anti-assignment provision prevents medical providers holding an assignment from pursuing a claim, as the Eleventh Circuit held, then the language of the plan that states that "a beneficiary includes a medical provider with a valid assignment" (App. 047) becomes a nullity. The Eleventh Circuit has sought to impose upon PMG an absolute bar to its' action asserting the applicability of the plan's anti-assignment provision. PMG respectfully asserts that not only was the Eleventh Circuit's decision in err, but it clearly conflicts with the Fifth Circuit's above referenced decisions which allowed a medical provider to proceed via derivative standing despite the subject plan containing a similar anti-assignment provision.

CONCLUSION

The circuit courts of appeal have wrestled with the issue of a medical providers' "independent" or "derivative" standing to assert an E.R.I.S.A. claim for years. Various circuit courts have ruled about every way possible on the issues. In *Mackey*, this Court held

that some E.R.I.S.A. benefits may be assigned, but this Court has, thus far, chosen not to address the issue of a medical providers' standing to sue under E.R.I.S.A. 29 U.S.C.S. § 1132(a)(1)(B). PMG respectfully submits that the matter *sub judice* presents a perfect opportunity for the court to address all of the above three sub-issues and to provide clear directive on the important issue of a medical providers' standing to assert an E.R.I.S.A. claim for benefits. As the Eleventh Circuit and the Fifth Circuit have noted, the issue of the right of medical providers to assert a claim under E.R.I.S.A. has far reaching public policy implications. Clearly, if a medical provider cannot assert a claim under E.R.I.S.A. then the alternative is for the medical provider to simply sue its' patient. The patient will usually respond by filing a separate suit against his insurer. Clearly, it is not in the interest of judicial economy for medical providers not to be able to pursue claims directly under E.R.I.S.A. If a medical provider can sue an E.R.I.S.A. plan directly then the result is that less lawsuits will be filed and the court systems resources will not be burdened any more than is necessary. Accordingly, PMG respectfully requests that this honorable Court grant the requested *writ of certiorari* so that this honorable Court might address the important issues raised herein.

Respectfully Submitted,

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*371 F.3d 1291, *; 2004 U.S. App. LEXIS 10827, **; 32 Employee Benefits Cas. (BNA) 2674; 17 Fla. L Weekly C 630*

PHYSICIANS MULTISPECIALTY GROUP,
Plaintiff-Appellee,
versus
THE HEALTH CARE PUN OF HORTON HOMES, INC., HORTON HOMES, INC.,
Defendants-Appellants.

No. 03-14202

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

371 F.3d 1291; 2004 U.S. App. LEXIS 10827;
32 Employee Benefits Cas. (BNA) 2674;
17 Fla. L. Weekly C 630

June 3, 2004, Decided
[Entered: June 3, 2004]

PRIOR HISTORY: Appeal from the United States District Court for the Southern District of Georgia. D. C. Docket No. 02-00102 CV-DHB-1.

DISPOSITION: Reversed and remanded.

CASE SUMMARY

PROCEDURAL POSTURE: Plaintiff medical group obtained a written assignment of benefits from an Employee Retirement Income Security Act (ERISA), 29

U.S.C.S. § 1001 et seq., plan beneficiary and sued defendants to recover the cost of medical services it rendered to the beneficiary. The United States District Court for the Southern District of Georgia granted summary judgment to the medical group on its ERISA claim, and defendants appealed.

OVERVIEW: The court concluded that ERISA's silence on the assignability issue could not be interpreted to mandate affirmatively an absolute right to assign. Rather, the court concluded that ERISA's silence on the assignability issue left the matter of assignability of welfare benefits to the agreement of the contracting parties. The plan provision in the case clearly provided that a participant or beneficiary could not assign benefits. That was a valid, enforceable provision. Thus, the medical group could not maintain an ERISA action.

OUTCOME: The judgment of the district court was reversed and remanded.

CORE TERMS: beneficiary, assignability, silence, anti-assignment, unambiguous, granting summary judgment, provider-assignee, providers, contracting parties, summary judgment, welfare benefit, health care, anti-assignability, enforceable, frivolous, administrator, alienation, assign, void, employee benefit plan, welfare benefit plan, eligible to receive, first impression, state law, derivative, purposed, pension, forbid, written assignment, applicable law

COUNSEL: For THE HEALTH CARE PLAN OF HORTON HOMES, INC., HORTON HOMES, INC., Appellants:

Cannon R. Carl, Constangy, Brooks & Smith, Atlanta, GA.
For **PHYSICIANS MULTISPECIALTY GROUP,** Appellee: Hoskins, Robert Edwards, Foster & Foster, Greenville, SC.

JUDGES: Before DUBINA and COX, Circuit Judges, and OWENS *, District Judge.

* Honorable Wilbur D. Owens, Jr., United States District Judge for the Middle District of Georgia, sitting by designation.

OPINIONBY: DUBINA

OPINION: DUBINA, Circuit Judge:

Appellants, Horton Homes, Inc. ("Horton Homes") and Health Care Plan of Horton Homes, Inc. (the "Plan"), appeal the district court's order granting summary judgment to Plaintiff-Appellee **Physicians' Multispecialty Group** ("PMG"), on its Employee Retirement Income Security Act (".ERISA") claim. Answering a question of first impression in our circuit, we reverse the district court's order granting summary judgment on the basis that the anti-assignment clause in the Plan precludes PMG from maintaining an ERISA action based on its reliance upon an assignment of benefits.

I. BACKGROUND

Horton Homes offered and funded a medical benefit plan to its employees pursuant to ERISA, 29 U.S.C.A. § 1001,

et seq. The Plan extended coverage to dependents of Horton Homes employees as long as the dependents met certain conditions.

In September 1999, Linton Franklin ("Franklin") began working for Horton Homes and enrolled himself, his daughter Candace Murray ("Murray"), and four other minor children in the Plan. In June 2001, Murray contracted a severe infection for which she was hospitalized and treated by physicians practicing with PMG. Murray remained hospitalized for over a month until she died on July 21, 2001.

Shortly after Murray's death, PMG obtained a written assignment from the administrator of Murray's estate and filed a claim with the Plan for $68,230 to recover the cost of medical services it rendered to Murray. ACS Benefit Services, Inc. ("ACS"), the Plan's third-party administrator, denied PMG's claim on the ground that Murray was not an eligible dependent child of Franklin because she was not "principally dependent" upon Franklin for financial support, as required by the Plan. PMG appealed ACS's denial of benefits to Horton Homes, which upheld ACS's decision. Horton Homes concluded that Murray was not "principally dependent" upon Franklin for support because Franklin's limited support of Murray was outweighed by other sources of support, such as Murray's own earnings from her part-time job.

PMG then initiated the present action, asserting an ERISA claim seeking to establish Murray's eligibility for benefits and to recover the costs of its medical services rendered, and two state law claims. PMG also sought attorneys'

fees and costs. The district court dismissed the state law claims by consent order. Concerned about PMG's ability to maintain an ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), action, the district court raised the issue *sua sponte* at the summary judgment hearing. Horton Homes followed the district court's lead and argued that PMG lacked statutory standing to bring suit. However, when Horton Homes declined to further address the statutory standing issue in its supplementary summary judgment briefing, the district court concluded that any dispute about PMG's standing was moot. Therefore, the district court granted PMG's motion for summary judgment and directed Horton Homes to pay PMG $68,230, or an amount that otherwise reflected the proper costs of the medical services PMG rendered to Murray.

II. ISSUE Whether the district court erred in granting summary judgment for PMG.

III. STANDARD OF REVIEW

This court reviews *de novo* the district court's order granting summary judgment. *McCormick v. City of Fort Lauderdale, Fla.*, 333 F.3d 1234, 1242-43 (11th Cir. 2003).

IV. DISCUSSION

Initially, PMS contends that Horton Homes waived the issue whether PMS had "standing" to sue under ERISA. We disagree since Horton Homes argued this issue to the district court. We also note that the

"standing" at issue here is not the standing label given to the subject-matter-jurisdictional doctrine of justiciability which considers injury, traceability to the defendant, and redressability. *See Northeastern Fla. Chapter of Associated Gen. Contractors v. City of Jacksonville*, 508 U.S. 656, 663-64, 113 S. Ct. 2297, 2302, 124 L. Ed. 2d 586 (1993). The jurisdictional question remaining here, where PMS has asserted a federal statutory cause of action, and where Horton Homes has challenged PMS's ability to maintain the action, is whether PMS has made a nonfrivolous claim under the statute that it invokes. *McGinnis v. Ingram Equip. Co.*, 918 F.2d 1491, 1494 (11th Cir. 1990) (en *banc).*

Thus, in the context of this ERISA case, we must determine whether PMG's claim that it was a beneficiary of the ERISA plan by virtue of its assignment from the administrator of Murray's estate, is either clearly immaterial and made solely for the purpose of obtaining jurisdiction or is wholly insubstantial or frivolous. *See Blue Cross & Blue Shield of Ala, v. Sanders,* 138 F.3d 1347, 1352-54 (11th Cir. 1998) (finding subject matter jurisdiction as Blue Cross's claim that it was a fiduciary for purposes of ERISA was not frivolous or made solely to obtain federal jurisdiction). We conclude that PMG's claim is not frivolous because it depends on our answer to the question of whether a provider-assignee can sue an ERISA plan, where the terms of the plan forbid such an assignment, which is an issue of first impression in this circuit. *See Cagle v. Bruner*, 112 F.3d 1510, 1516, n.3 (11th Cir. 1997).

Under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), two categories of persons exist who can sue for benefits under an ERISA-governed plan: plan beneficiaries[1] and plan participants[2]. 29 U.S.C. § 1132(a)(1); *Hobbs v. Blue Cross Blue Shield of Ala.*, 276 F.3d 1236, 1241 (11th Cir. 2001). Healthcare providers, such as PMG, are generally not "participants" or "beneficiaries" under ERISA and thus lack independent standing to sue under ERISA. Hobbs, 276 at 1241; *See also Cagle*, 112 F.3d at 1514. Healthcare providers may acquire derivative standing, however, by obtaining a written assignment from a "beneficiary" or "participant" of his right to payment of benefits under an ERISA-governed plan. *Hobbs*, 276 F.3d at 1241.

Although ERISA § 206(d), 29 U.S.C. § 1056(d), expressly prohibits assignment of pension benefits, this court has commented that "neither 1132(a) nor

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1 ERISA defines "beneficiary" to mean "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

2 ERISA defines "participant" as

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7).

any other ERISA provision prevents derivative standing based upon an assignment of rights from [ERISA participants or beneficiaries.]" *HCA Health Servs. Of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 991 (11th Cir. 2001) (quoting *Cagle*, 112 F.3d at 1515). This court stated in *Cagle* that:

> if provider-assignees cannot sue the ERISA plan for payment, they will bill the participant or beneficiary directly for the insured['s] medical bills, and the participant or beneficiary will be required to bring suit against the benefit plan when claims go unpaid. On the other hand, if provider-assignees can sue for payment of benefits, an assignment will transfer the burden of bringing suit from plan participants and beneficiaries to providers, who are better situated and financed to pursue an action for benefits owed for their services.

Cagle, 112 F.3d at 1515 (internal citations and quotations omitted).

Although *Cagle* favors the recognition of assignments in ERISA-governed plans, *Cagle* does not control the outcome of this case. The *Cagle* court expressly declined to consider the issue with which we are faced today: "whether a provider-assignee can sue an ERISA plan, where the terms of the plan forbid such an assignment." *Cagle*, 112 F.3d at 1516, n.3. The Plan at issue contains such a provision:

ASSIGNABILITY

> Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by . . . assignment... of any kind[]. Any attempt to ... assign . . . any such amount, whether presently or hereafter payable, shall be void. . . .

[Vol. 1, Doc. 14, Exh. A, at 24].

Considering this issue, we are persuaded by the reasoning of the majority of federal courts that have concluded that an assignment is ineffectual if the plan contains an unambiguous anti-assignment provision. *See, e.g., City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) ("Consistent with the other circuits which have addressed this issue, we hold that ERISA leaves the assignability or non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties."); *St. Francis Reg'I Med. Ctr. v. Blue Cross S Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1464-65 (10th Cir. 1995) ("ERISA's silence on the issue of the assignability of insurance benefits leaves the matter to the agreement of the contracting parties."); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991) ("As a general rule of law, where the parties' intent is clear, courts will enforce non-assignment provisions."); *Washington Hosp. Ctr. Corp. v. Group Hospitalization and Med. Servs., Inc.*, 758 F. Supp. 750, 755 (D.D.C. 1991) (holding that an anti-assignment

provision was valid and enforceable after *concluding* that enforcement of the provision was not contrary to public policy); *see also, e.g., Neurological Res., P.C. v. Anthem Ins. Cos.*, 61 F. Supp. 2d 840, 845-46 (S.D. Ind. 1999); *Renfrew Ctr. v. Blue Cross & Blue Shield of Cent. N.Y., Inc.*, 1997 U.S. Dist. LEXIS 5088, No. 94-CV-1527, 1997 WL 204309, at *3-4 (N.D.N.Y. Apr. 10, 1997); *Home Nutritional Servs., Inc. v. Blue Cross & Blue Shield of Mass., Inc.*, 1993 U.S. Dist. LEXIS 12240, Nos. 93-CV-10211-Z, 93-CV-10658-Z, 1993 WL 343674, at *1-2 (D. Mass. Aug. 24, 1993); *Parkside Lutheran Hosp. v. R.J. Zeltner & Assocs., Inc.*, 788 F. Supp. 1002, 1004-05 (N. D. Ill. 1992).

In deciding that an unambiguous anti-assignability provision in an ERISA-governed plan voids any purposed assignment, the Ninth Circuit began by noting that any construction of ERISA must be consistent with Congressional intent. *Davidowitz*, 946 F.2d at 1480. "Even if it could be said that required assignability promotes certain ERISA policies, this Court would not create a construction requiring assignability in the face of Congressional silence on the issue." *Id. See also St. Francis Reg'l Med. Ctr.*, 49 F.3d at 1465.

The *Davidowitz* court further noted that the Supreme Court has stated that Congress carefully considered assignment of both pension and welfare benefit plans and consciously decided to prohibit assignment of pension plans but remained silent on the assignment of welfare benefit plans. See *Mackey v. Lamer Collection Agency & Service, Inc.*, 486 U.S. 825, 837, 108 S. Ct. 2182, 2189, 100 L. Ed. 2d 836 (1988) ("[Congress] had before it a provision to bar the alienation or garnishment of ERISA plan benefits, and chose to impose that limitation only

with respect to ERISA pension benefit plans, and *not* ERISA welfare benefit plans. In a comprehensive regulatory scheme like ERISA, such omissions are significant ones."). In sum, the *Davidowitz* court found that it could not agree that Congressional silence on the issue shows a Congressional intent to mandate assignability. "On the contrary, if Congress had intended this result, it could have said so." *Davidowitz*, 946 F.2d at 1480. The court concluded that Congress "intended instead to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve." *Id.* at 1481.

We agree with *Davidowitz* and *St. Francis Reg'l. Med. Ctr.* that Congressional silence on the issue does not mandate a Congressional intent to mandate assignability. Because ERISA-governed plans are contracts, the parties are free to bargain for certain provisions in the plan - like assignability. Thus, an unambiguous anti-assignment provision in an ERISA-governed welfare benefit plan is valid and enforceable.

Having determined that an unambiguous anti-assignability provision in an ERISA-governed welfare benefit plan voids any purposed assignment, we must consider whether the anti-assignability provision in this Plan is unambiguous. We conclude that it is. The provision states in clear terms that except as applicable law may otherwise require, no amount payable at any time . . . shall be subject in any manner to alienation by ... assignment ... of any kind[]." By its own terms, the provision clearly and unambiguously prohibits Murray from assigning benefits to PMG. Accordingly, the anti-

assignment clause precludes PMS's maintenance of an ERISA action.

V. CONCLUSION

We conclude that ERISA's silence on the assignability issue cannot be interpreted to mandate affirmatively an absolute right to assign. Rather, we conclude that ERISA's silence on the assignability issue leaves the matter of assignability of welfare benefits to the agreement of the contracting parties. The Plan provision in this case clearly provides that a participant or beneficiary cannot assign benefits. This is a valid, enforceable provision. Thus, PMG cannot maintain an ERISA action. Accordingly, we reverse the district court's grant of summary judgment and remand this case to the district court for further proceedings consistent with this opinion.

REVERSED and REMANDED.

IN THE UNITED STATES DISTRICT COURT
FOR SOUTHERN DISTRICT OF GEORGIA
AUGUSTA DIVISION

PHYSICIANS' MULTISPECIALTY GROUP,
Plaintiff,

vs. CV102-102

THE HEALTH CARE PLAN OF
HORTON HOMES, INC.;
HORTON HOMES, INC.,
Defendants.

ORDER

[Entered: August 4, 2003]

Plaintiff filed suit to recover its expenses for treating a patient it contends was insured by the Healtih Care Plan of Horton Homes (the "Plan"). Plaintiff initially asserted three claims, but this Court dismissed two of those claims by consent order. (Doc. No. 23.) The remaining claim involves the Employee Retirement Income Security Act of 1974, 29 U.S.C.A. § 1001 et seq. Both sides now move for summary judgment. (Doc. Nos. 14, 24.) For the reasons stated below, Plaintiff's motion is **GRANTED**, and Defendants' motion is **DENIED**.

Background

Horton Homes offered a medical benefit plan to its employees ("the Plan"), pursuant to the Employee

Retirement Income Security Act of 1974, 29 U.S.C.A. § 1001, et. seq. (ERISA). Horton Homes administered and funded the Plan. The Plan extended coverage to the dependent children of Horton Homes employees as long as those children met four conditions. One such condition stated the covered child had to be:

> a natural child; a stepchild; a legally adopted child (final adoption before attaining age eighteen (18) & a child who is being placed for adoption before attaining age eighteen (18); or a foster child. The child must be principally dependent upon the Participant for financial support and a child for whom the Participant has legal responsibility to support. A child will be assumed a dependent if such child is claimed as a dependent for federal income tax purposes. Further proof also may be required that the Participant is legally responsible for the child's health care.

(Doc. No. 14, Ex. A., at 25.)

On September 27, 1999, Linton Franklin ("Franklin") began working for Horton Homes. Shortly after he started working, Franklin enrolled his daughter, Candace Murray ("Murray"), in the Plan and contributed to the Plan on her behalf. In addition to paying for Murray's health insurance, Franklin provided Murray $90 a month in court-ordered child support.[1]

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[1] While Murray was alive, Franklin owed $80 a month for current support and $10 a month for support that was past due. (Doc. No. 14, Ex. A, at 181.)

Plaintiff contends that Horton Homes was aware of Franklin's obligation because the child support payments were deducted from his Horton Homes paycheck beginning on November 5, 1999. Plaintiff contends that Franklin provided support for Murray above and beyond what the court ordered him to provide. Despite the support Franklin provided, he never claimed Murray as a dependent on his income tax returns. In addition, Murray never lived with Franklin.

The day before Franklin began working for Horton Homes, Murray began working for a fast food restaurant where she earned $5.15 an hour. From September 1999 through May 2001, Murray earned an average of $223 a month. In addition to the money Murray made, Murray's mother received $280 a month in public assistance based in part on her obligation to support Murray. However, it is unclear from the record how much of the public assistance funds Murray's mother used to support Murray.

In June 2001, Murray contracted a severe infection that caused her death on July 21, 2001. Doctors practicing with Physicians' Multispeciality Group treated Murray for the infection and rendered services totaling $68,230.00.[2] Plaintiff filed a claim for that amount. On November 9, 2001, ACS Benefit Services, the Plan's third-party administrator, denied Plaintiff's claim. It is noteworthy, however, that the

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[2] Doctor's Hospital rendered services to Murray totaling nearly $1,000,000; however, Doctor's Hospital has not filed suit against Defendant in this Court.

Plan covered six claims filed on Murray's behalf in 2000 that totaled approximately $400.

Plaintiff appealed ACS's denial of benefits to Horton Homes. Horton Homes upheld ACS's decision (asserting that Murray was not eligible for coverage because she was not "principally dependent" upon Franklin for support. (Doc. No. 14, Ex. A, at 178-80.) Three months after receiving the final denial, Plaintiff filed suit in this Court.

Plaintiff wants this Court to declare that Murray was an eligible participant under 29 U.S.C.A. § 1132(a)(1)(B). According to Plaintiff, if the Court finds that Murray was an eligible participant, Plaintiff would be a beneficiary entitled to payment for the services it rendered. Horton Homes counters that Murray was not an eligible participant because she was not "principally dependent" upon Franklin.[3]

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[3] Concerned that Defendants had not disputed Plaintiff's standing in its summary judgment briefs, I asked the parties at the July 9 hearing about their positions on Plaintiff's standing. For the first time, defense counsel asserted that Plaintiff lacked standing to bring suit. At that hearing, I instructed the parties to re-brief any issues they considered deserving of further discussion. Although Plaintiff reiterated its position that it had standing, Defendants once again failed to discuss the matter. In addition to Defendants' failure to brief the issue, the parties consented in an earlier order to dismiss the state-law claims and to argue the case under ERISA. (Doc. No. 23.) Defendant's failure to contest standing in its most recent brief and the previous consent order lead me to conclude that any dispute about Plaintiff's standing is moot.

Requirements for Summary Judgment

The Court should grant summary judgment only if "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). Facts are "material" if they could affect the outcome of the suit under the governing substantive law. Anderson v. Liberty Lobby. Inc., 477 U.S. 242, 248 (1986). The Court must view the facts in the light most favorable to the non-moving party, Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986), and must draw "all justifiable inferences in [its] favor," United States v. Four Parcels of Real Property, 941 F.2d 1428, 1437 (11th Cir. 1991) (en bane) {internal punctuation and citations omitted).

The moving party has the initial burden of showing the Court, by reference to materials on file, the basis for the motion. Celotex Corp. v. Catrett, 477 U.S. 317, 323 (1986). How to carry this burden depends on who bears the burden of proof at trial. Fitzpatrick v. City of Atlanta, 2 F.3d 1112, 1115 (11th Cir. 1993). If the movant bears the burden of proof at trial, that party "must show that, on all the essential elements of its case, ... no reasonable jury could find for the non-moving party." Four Parcels, 941 F.2d at 1438. On the other hand, if the non-movant has the burden of proof at trial, the movant may carry the initial burden in one of two ways -- by negating an essential element of the non-movant's case or by showing that there is no evidence to prove a fact necessary to the non-movant's case. See Clark v. Coats & Clark, Inc., 929 F.2d 604, 606-08 (11th Cir. 1991) (explaining Adickes v. S.H.

Kress & Co., 398 U.S. 144 (1970) and Celotex Corp. v. Catrett, 477 U.S. 317 (1986)). Before the Court can evaluate the non-movant's response in opposition, it must first consider whether the movant has met its initial burden of showing that there are no genuine issues of material fact and that it is entitled to judgment as a matter of law. Jones v. City of Columbus, 120 F.3d 248, 254 (11th Cir. 1997) (per curiam). A mere conclusory statement that the non-movant cannot meet the burden at trial is insufficient. Clark, 929 F.2d at 608.

If -- and only if -- the movant carries its initial burden, the non-movant may avoid summary judgment only by "demonstrat[ing] that there is indeed a material issue of fact that precludes summary judgment." Id. Again, how to carry this burden depends on who bears the burden of proof at trial. If the movant has the burden of proof at trial, the non-movant may avoid summary judgment only by coming forward with evidence from which a reasonable jury could find in its favor. Anderson, 477 U.S. at 249. If the non-movant bears the burden of proof at trial, the non-movant must tailor its response to the method by which the movant carries its initial burden. If the movant presents evidence affirmatively negating a material fact, the non-movant "must respond with evidences sufficient to withstand a directed verdict motion at trial on the material fact sought to be negated." Fitzpatrick, 2 F.3d at 1116. If the movant shows an absence of evidence on a material fact, the non-movant must either show that the record contains evidence that was "overlooked or ignored" by the movant or "come forward with additional evidence sufficient to

withstand a directed verdict motion at trial based on the alleged evidentiary deficiency." Id. at 1116-17. The non-movant cannot carry its burden by relying on the pleadings or by repeating conclusory allegations contained in the complaint. See Morris v. Ross, 663 F.2d 1032, 1033-34 (11th Cir. 1981). Rather, the non-movant must respond by affidavits or as otherwise provided by Rule 56.

The Clerk has given the parties notice of the summary judgment motions and the summary judgment rules, of the right to file affidavits or other materials in opposition, and of the consequences of default. {Doc. Nos. 16, 26.) Therefore, the notice requirements of Griffith v. Wainwright, 772 F.2d 822, 825 (11th Cir. 1985) (per curiam), are satisfied. The time for filing materials in opposition has expired, and the motions are ripe for consideration.

III. Analysis

A. Standard of Review

The Eleventh Circuit "has adopted the following standards for reviewing administrators' plan interpretations: (1) de novo where the plan does not grant the administrator discretion[;J (2) arbitrary and capricious [where] the plan grants the administrator discretion; and (3) heightened arbitrary and capricious where there is a conflict of interest." HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co., 240 F.3d 982, 993 (11th Cir. 2001). When a court reviews a claims administrator's benefits determination, the court must follow a series of steps.

Id. At each step, the court makes a determination that results in either the progression to the next step or the end of the inquiry. Id.

First, the Court must look to the plan documents to determine whether the administrator has discretion to interpret disputed terms. Id. If the plan contains language conferring discretion, then the Court applies the arbitrary and capricious review and possibly the heightened arbitrary and capricious review. Id.

Regardless of which form of arbitrary and capricious review applies, the Court must first evaluate whether the administrator's interpretation of the plan is "wrong." Id. "Wrong is the label used . . . to describe the conclusion a court reaches when, after reviewing the plan documents and disputed terms de novo, the court disagrees with the claims administrator's plan interpretation." Id. at 994 (internal quotation marks omitted)(citation omitted). If the Court determines that the administrator's interpretation is not wrong, then that interpretation will stand. If, however, the Court determines that the administrator's interpretation is wrong, then the Court considers whether the claimant has proposed a reasonable interpretation of the plan. Id.

A claimant's interpretation is deemed reasonable if an ERISA plan contains ambiguous language that affects whether a claim for benefits is covered. See Lee v. Blue Cross/Blue Shield of Ala., 10 F.3d 1547, 1551 (11th Cir. 1994) (principle of contra proferentem requires that ambiguities be construed against the drafter of a document) ; see also Florence Nightingale

Nursing Serv., Inc. v. Blue Cross/Blue Shield of Ala., 41 F.3d 1476, 1481 (11th Cir. 1995). However, the claimant does not necessarily prevail even if he proposes a reasonable interpretation. HCA Health Servs. of Ga., Inc., 240 F.3d at 993. If the plan administrator's wrong interpretation is unreasonable, then the claimant prevails. But, if the administrator's wrong decision is nonetheless reasonable, then that interpretation is entitled to deference even though the claimant's interpretation is also reasonable. Id.

The deference owed to a plan administrator's wrong but reasonable interpretation is diminished, however, if the administrator suffers from a conflict of interest. Id. If no such conflict exists, then the arbitrary and capricious review applies and the administrator's wrong but reasonable decision will stand. Id. However, if a conflict of interest exists, then heightened arbitrary and capricious review applies and the burden shifts to the administrator to prove that its decision was not tainted by self-interest. Id. An administrator can satisfy that burden by showing that its interpretation benefits participants and beneficiaries. If that showing is not made, then the administrator's interpretation will not stand. Id. at 995.

B. Application of the Standard

The Plain contains language conferring discretion upon Horton Homes to interpret disputed terms. Specifically, the Plan bestowed upon Horton Homes "the sole authority and responsibility to review and make final decisions on Plan matters such as benefit

adjudication, eligibility for coverage determinations and construing terms." (Docs. No. 14, Ex. A., at 18.) Because the Plan grants discretion to the administrator to interpret the terms of the Plan, de novo review is inapplicable and at a minimum, arbitrary and capricious review applies.

Next, I must decide if Horton Homes's interpretation was wrong. Asserting that Murray was not a dependent child as defined by the Plan, Horton Homes contends that its interpretation of the Plan was correct. In support of its decision to deny Plaintiff's claim, Horton Homes maintains that the only plausible interpretation of the phrase "principally dependent" would require Franklin to provide more financial support to Murray than any other single source. Horton Homes asserts Franklin did not provide such support, thereby rendering Murray ineligible for coverage. This Court disagrees with Horton Homes's interpretation.

When ACS was considering Plaintiff's claim, it asked Franklin several questions concerning the support he provided to Murray. (Doc. No. 41, Ex. A.) On the questionnaire, Franklin revealed that he paid $90.00 a month in child support and that he provided "whatever she called and stated she needed. " (Id.) Specifically, Franklin declared that he provided Murray with school supplies and gave her money for clothes. (Id.)

Horton Homes points out that Murray received financial support from sources other than Franklin. Murray's mother received $280 a month in public assistance for the support of her children. At the

hearing, however, neither side knew how many children Murray's mother supported with the public assistance funds. Consequently, it is unclear how much of the $280 was used to support Murray. The Court declines to presume that the amount of public assistance funds used to support Murray exceeded the amount Franklin provided.

Additionally, Murray made approximately $220 a month from her part-time job. Defendant contends that because she made more money that what she received from her father, Murray cannot be considered "principally dependent" upon her father. The Plan, however, does not disqualify a dependent child from coverage because that child has a part-time job. (Doc. No. 14, Ex. A, at 25.) Moreover, there is no evidence in the record that Murray used the money to support herself. Because Murray was a mother, it is possible that she used the money from her after-school job to support her own children.

The interpretation of the dependent child provision upon which Horton Homes based its denial of Plaintiff's claim was wrong. The amount of support from Murray's mother has not been sufficiently quantified. Additionally, it is unclear whether Murray used the money she made at her part-time job to support herself. The amount of support Franklin provided is the only support about which the Court has specific evidence.

Having determined that Horton Homes's interpretation of the Plan was wrong, the Court must decide if Plaintiff's interpretation is reasonable.

Plaintiff contends that the policy is ambiguous because it does not specify whether a child can be "principally dependent" upon more than one person. According to Webster's Dictionary, the adverb "principally" means "in a principal manner." Webster's Third New International Dictionary 1803 (4th ed. 1976). The adjective "principal" has several meanings. Although principal means "most important, consequential or influential," it can also mean "the person primarily liable on a legal obligation." Id. at 1802.

Depending upon the meaning assigned to the word "principally," a child could be "principally dependent" upon more than one person. For example, assume that a divorced couple has a child and the mother has custody of that child. Assume further that the father pays child support pursuant to a court order, but the mother makes more money than the father. In that instance, the child could "principally dependent" on either parent. Horton Homes's failure to specify the exact meaning of "principally" and whether the term allowed for a child to be "principally dependent" upon more than one person renders that provision ambiguous. The rule of contra proferentem requires that the ambiguity be construed against the drafter of the Plan. Consequently, Plaintiff's interpretation is reasonable.

In addition to the ambiguous terminology contained in the dependent child provision, Horton Homes's payment of previous claims supports the conclusion that Plaintiff's interpretation is reasonable. See Lee, 10 F.3d at 1551 (noting that Plaintiff's interpretation of

plan was reasonable, in part because insurance company paid for Plaintiff's first visit to orthodontist). In 2000, Horton Homes paid six claims totaling $386.91 filed on Murray's behalf. (Doc. No. 18, Ex. B.) In light of Horton Homes's payment of these six claims. Plaintiff's interpretation is reasonable.

Having determined that Plaintiff's interpretation is reasonable, the Court must consider whether Norton Homes's wrong interpretation is nonetheless reasonable. To make that determination, the Court must evaluate whether Horton Homes's decision was tainted by self-interest. The Plan is both funded and administered by Horton Homes.[4] As such, Horton Homes pays the claims and decides which claims are paid. This arrangement typifies a conflict of interest because it is to Horton Homes's benefit to deny the payment of claims.

Although Horton Homes suffered from a conflict of interest, it can purge itself of the taint of self-interest by showing that its interpretation was "calculated to maximize benefits to participants in a cost-efficient manner." Lee, 10 F.3d at 1552. Construing the term "principally dependent" to mean that a participant must provide more financial support to a child than any other source of support would not maximize benefits to the participants. In fact, it may leave many participants without coverage for the medical treatment of their children.

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[4] Although a third-party administrator made the initial benefit determination, Horton Homes denied the claim on appeal.

The following hypothetical illustrates this point. Suppose a married couple has a child. The husband is an independent contractor who fixes computers for several businesses, and the wife works as a janitor for Horton Homes. Because the husband is self-employed, the couple enrolls themselves and their child in the insurance plan offered by the wife's employer, Horton Homes. Suppose further that the husband makes more money than the wife, which he uses to support his family. Assume also that the couple files separate federal income tax returns and the father claims the child as a dependent. If the Court were to construe "principally dependent" in the manner Horton Homes suggests, the child would not be eligible for coverage because her father, the non-participant, provided more financial support than her mother, the participant. Interpreting the Plan in a manner that renders the children of participants ineligible for coverage serves the interests of Horton Homes, not the Plan participants. Consequently, Horton Homes's plan interpretation is not entitled to deference.

IV. Conclusion

Based upon the foregoing analysis, I find that Horton Homes's interpretation of the Plan is arbitrary and capricious. Accordingly, Plaintiff's motion for summary judgment (Doc .No. 14) is **GRANTED**, and Defendants' motion for summary

judgment (Doc. No. 24) is **DENIED**.[5] Defendant Horton Homes is directed to pay Plaintiff $68,230.00, the amount originally sought by Plaintiff, or an amount that otherwise reflects the proper costs of the medical services rendered. The Clerk is instructed to **CLOSE** this case and to enter **FINAL JUDGMENT** in favor of Plaintiff. Costs are taxed against Defendants.

ORDER ENTERED at Augusta, Georgia, this 4th day of August 2003.

/s/Dudley H. Bowen Jr.
CHIEF UNITED STATES DISTRICT JUDGE

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[5] Defendant moved to strike the affidavit of Pamela Murray proffered by Plaintiff. (Doc. No. 43) Because the Court did not rely on Pamela Murray's testimony to resolve the cross motions for summary judgment, Defendant's motion (Doc. No. 44) is **MOOT**.

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 03-14202-GG

PHYSICIANS MULTISPECIALTY GROUP,

Plaintiff - Appellee,

Versus

THE HEALTH CARE PLAN OF HORTON HOMES, INC., HORTON HOMES, INC.,

Defendants - Appellants.

On Appeal from the United States District Court for the Southern District of Georgia

ON PETITION(S) FOR REHEARING AND
PETITION(S) FOR REHEARING EN BANC
(Opinion _____, 11th Cir., 19__, ___ F.2d ____).

[Entered: July 23, 2004]

Before: DUBINA and COX, Circuit Judges, and OWENS* District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active

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* Honorable Wilbur D. Owens, Jr., United States District Judge for the Middle District of Georgia, sitting by designation.

service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/United States Circuit Judge
UNITED STATES CIRCUIT JUDGE

29 USCS § 1002

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*** CURRENT THROUGH P.L. 108-302, APPROVED 8/17/04 ***

TITLE 29. LABOR
CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
PROTECTION OF EMPLOYEE BENEFIT RIGHTS
GENERAL PROVISIONS

29 USCS § 1002 (2004)

§ 1002. Definitions

For purposes of this title:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship

funds, or prepaid legal services, or (B) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions).

(2) (A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program—

(i) provided retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan.

(B) The Secretary may by regulation prescribe rules consistent with the standards and purposes of this Act providing one or more exempt categories under which—

(i) severance pay arrangements, and

(ii) supplemental retirement income payments, under which the pension benefits of retirees or their beneficiaries are supplemented to take into account some portion or all of the increases in the cost of living (as determined by the Secretary of Labor) since retirement, shall, for purposes of this title, be treated as welfare plans rather than pension plans. In the case of any arrangement or payment a principal effect of which is the evasion of the standards or purposes of this Act applicable to pension plans, such arrangement or payment shall be treated as a pension plan.

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act [43 U.S.C. 1331-1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the meaning of the Labor Management Relations Act, 1947, or the Railway Labor Act.

(13) The term "Secretary" means the Secretary of Labor.

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E)an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation.[,]

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise, which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or(E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

29 USCS § 1056

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*** CURRENT THROUGH P.L 108-302, APPROVED 8/17/04 ***

TITLE 29. LABOR
CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
PROTECTION OF EMPLOYEE BENEFIT RIGHTS
REGULATORY PROVISIONS
PARTICIPATION AND VESTING

29 USCS § 1056 (2004)

§ 1056. Form and payment of benefits

(a) Commencement date for payment of benefits. Each pension plan shall provide that unless the participant otherwise elects, the payment of benefits under the plan to the participant shall begin not later than the 60th day after the latest of the close of the plan year in which—

(1) occurs the date on which the participant attains the earlier of age 65 or the normal retirement age specified under the plan,

(2) occurs the 10th anniversary of the year in which the participant commenced participation in the plan, or

(3) the participant terminates his service with the employer.

In the case of a plan which provides for the payment of an early retirement benefit, such plan shall provide that a participant who satisfied the service requirements for such early retirement benefit, but separated from the service (with any nonforfeitable right to an accrued benefit) before satisfying the age requirement for such early retirement benefit, is entitled upon satisfaction of such age requirement to receive a benefit not less than the benefit to which he would be entitled at the normal retirement age, actuarially reduced under regulations prescribed by the Secretary of the Treasury.

(b) Decrease in plan benefits by reason of increases in benefit levels under Social Security Act or Railroad Retirement Act of 1937. If-

(1) a participant or beneficiary is receiving benefits under a pension plan, or

(2) a participant is separated from the service and has nonforfeitable rights to benefits, a plan may not decrease benefits of such a participant by reason of any increase in the benefit levels payable under title II of the Social Security Act [42 USCS §§ 401 et seq.] or the Railroad Retirement Act of 1937, or any increase in the wage base under such title II [42 USCS §§ 401 et seq.], if such increase takes place after the date of the enactment of this Act [enacted Sept. 2, 1974] or (if later) the earlier of the date of first entitlement of such benefits or the date of such separation.

(c) Forfeitures of accrued benefits derived from employer contributions. No pension plan may provide that any part of a participant's accrued benefit derived from employer contributions (whether or not otherwise nonforfeitable) is forfeitable solely because of withdrawal by such participant of any amount attributable to the benefit derived from contributions made by such participant. The preceding sentence shall not apply (1) to the accrued benefit of any participant unless, at the time of such withdrawal, such participant has a nonforfeitable right to at least 50 percent of such accrued benefit, or (2) to the extent that an accrued benefit is permitted to be forfeited in accordance with section 203(a)(3)(D)(iii) [29 USCS § 1053(a)(3)(D)(iii)].

(d) Assignment or alienation of plan benefits.

(1) Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated.

(2) For the purposes of paragraph (1) of this subsection, there shall not be taken into account any voluntary and revocable assignment of not to exceed 10 percent of any benefit payment, or of any irrevocable assignment or alienation of benefits executed before the date of enactment of this Act [enacted Sept. 2, 1974]. The preceding sentence shall not apply to any assignment or alienation made for the purposes of defraying plan administration costs. For purposes of this paragraph a loan made to a participant or beneficiary shall not be treated as an assignment or alienation if such loan is secured by the participant's accrued nonforfeitable

benefit and is exempt from the tax imposed by section 4975 of the Internal Revenue Code of 1986 [26 USCS § 4975] (relating to tax on prohibited transactions) by reason of section 4975(d)(1) of such Code [26 USCS § 4975(d)(1)].

(3) (A) Paragraph (1) shall apply to the creation, assignment, or recognition of a right to any benefit payable with respect to a participant pursuant to a domestic relations order, except that paragraph (1) shall not apply if the order is determined to be a qualified domestic relations order. Each pension plan shall provide for the payment of benefits in accordance with the applicable requirements of any qualified domestic relations order.

(B) For purposes of this paragraph—

(i) the term "qualified domestic relations order" means a domestic relations order—

(I) which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the benefits payable with respect to a participant under a plan, and

(II) with respect to which the requirements of subparagraphs (C) and (D) are met, and

(ii) the term "domestic relations order" means any judgment, decree, or order (including approval of a property settlement agreement) which—

(I) relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child, or other dependent of a participant, and

(II) is made pursuant to a State domestic relations law (including a community property law).

(C) A domestic relations order meets the requirements of this subparagraph only if such order clearly specifies—

(i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate payee covered by the order,

(ii) the amount or percentage of the participant's benefits to be paid by the plan to each such alternate payee, or the manner in which such amount or percentage is to be determined.

(iii)the number of payments or period to which such order applies, and

(iv) each plan to which such order applies.

(D) A domestic relations order meets the requirements of this subparagraph only if such order—

(i) does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan,

(ii) does not require the plan to provide increased benefits (determined on the basis of actuarial value), and

(iii)does not require the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined to be a qualified domestic relations order.

(E) (i) A domestic relations order shall not be treated as failing to meet the requirements of clause (i) of subparagraph (D) solely because such order requires that payment of benefits be made to an alternate payee—

(I) on or in the case of any payment before a participant has separated from service, after the date on which the participant attains (or would have attained) the earliest retirement age,

(II) as if the participant had retired on the date on which such payment is to begin under such order (but taking into account only the present value of benefits actually accrued and not taking into account the present value of any employer subsidy for early retirement), and

(III) in any form in which such benefits may be paid under the plan to the participant (other than in the form of a joint and survivor annuity with respect to the alternate payee and his or her subsequent spouse).

For purposes of subclause (II), the interest rate assumption used in determining the present value shall

be the interest rate specified in the plan or, if no rate is specified, 5 percent.

(ii) For purposes of this subparagraph, the term "earliest retirement age" means the earlier of—

(I) the date on which the participant is entitled to a distribution under the plan, or

(II) the later of the date of the participant attains age 50 or the earliest date on which the participant could begin receiving benefits under the plan if the participant separated from service.

(F) To the extent provided in any qualified domestic relations order—

(i) the former spouse of a participant shall be treated as a surviving spouse of such participant for purposes of section 205 [29 USCS § 1055] (and any spouse of the participant shall not be treated as a spouse of the participant for such purposes), and

(ii) if married for at least 1 year, the surviving former spouse shall be treated as meeting the requirements of section 205(f) [29 USCS § 1055(f)].

(G) (i) In the case of any domestic relations order received by a plan—

(I) the plan administrator shall promptly notify the participant and each alternate payee of the receipt of such order and the plan's procedures for

determining the qualified status of domestic relations orders, and

(II) within a reasonable period after receipt of such order, the plan administrator shall determine whether such order is a qualified domestic relations order and notify the participant and each alternate payee of such determination.

(ii) Each plan shall establish reasonable procedures to determine the qualified status of domestic relations orders and to administer distributions under such qualified orders. Such procedures—

(I) shall be in writing,

(II) shall provide for the notification of each person specified in a domestic relations order as entitled to payment of benefits under the plan (at the address included in the domestic relations order) of such procedures promptly upon receipt by the plan of the domestic relations order, and

(III) shall permit an alternate payee to designate a representative for receipt of copies of notices that are sent to the alternate payee with respect to a domestic relations order.

(H)(i) During any period in which the issue of whether a domestic relations order is a qualified domestic relations order is being determined (by the plan administrator, by a court of competent jurisdiction, or otherwise), the plan administrator shall separately account for the amounts (hereinafter in this

subparagraph referred to as the "segregated amounts") which would have been payable to the alternate payee during such period if the order had been determined to be a qualified domestic relations order.

(ii) If within the 18-month period described in clause (v) the order (or modification thereof) is determined to be a qualified domestic relations order, the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons entitled thereto.

(iii) If within the 18-month period described in clause (v)~

(I) it is determined that the order is not a qualified domestic relations order, or

(II) the issue as to whether such order is a qualified domestic relations order is not resolved,

then the plan administrator shall pay the segregated amounts (including any interest thereon) to the person or persons who would have been entitled to such amounts if there had been no order.

(iv) Any determination that an order is a qualified domestic relations order which is made after the close of the 18-month period described in clause (v) shall be applied prospectively only.

(v) For purposes of this subparagraph, the 18-month period described in this clause is the 18-month period beginning with the date on which the first

payment would be required to be made under the domestic relations order.

(I) If a plan fiduciary acts in accordance with part 4 of this subtitle [29JJSCS .§§ 1101 et seq.] in—

(i) treating a domestic relations order as being (or not being) a qualified domestic relations order, or

(ii) taking action under subparagraph (H),

then the plan's obligation to the participant and each alternate payee shall be discharged to the extent of any payment made pursuant to such Act.

(J) A person who is an alternate payee under a qualified domestic relations order shall be considered for purposes of any provision of this Act a beneficiary under the plan. Nothing in the preceding sentence shall permit a requirement under section 4001 [29 USCS § 1301] of the payment of more than 1 premium with respect to a participant for any period.

(K) The term "alternate payee" means any spouse, former spouse, child, or other dependent of a participant who Is recognized by a domestic relations order as having a right to receive all, or a portion of, the benefits payable under a plan with respect to such participant.

(L) This paragraph shall not apply to any plan to which paragraph (1) does not apply.

(M) Payment of benefits by a pension plan in accordance with the applicable requirements of a

qualified domestic relations order shall not be treated as garnishment for purposes of section 303(a) of the Consumer Credit Protection Act [15 USCS § 1673(a)],

(N)In prescribing regulations under this paragraph, the Secretary shall consult with the Secretary of the Treasury.

(4) Paragraph (1) shall not apply to any offset of a participant's benefits provided under an employee pension benefit plan against an amount that the participant is ordered or required to pay to the plan if—

(A) the order or requirement to pay arises—

(i) under a judgment of conviction for a crime involving such plan,

(ii) under a civil judgment (including a consent order or decree) entered by a court in an action brought in connection with a violation (or alleged violation) of part 4 of this subtitle [29 USCS §§ 1101 et seq.], or

(iii)pursuant to a settlement agreement between the Secretary and the participant, or a settlement agreement between the Pension Benefit Guaranty Corporation and the participant, in connection with a violation (or alleged violation) of part 4 of this subtitle [29 USCS §§ 1101 et seq.] by a fiduciary or any other person,

(B) the judgment, order, decree, or settlement agreement expressly provides for the offset of all or part

of the amount ordered or required to be paid to the plan against the participant's benefits provided under the plan, and

(C) in a case in which the survivor annuity requirements of section 205 [29 USCS § 1055] apply with respect to distributions from the plan to the participant, if the participant has a spouse at the time at which the offset is to be made--

(i) either-

(I) such spouse has consented in writing to such offset and such consent is witnessed by a notary public or representative of the plan (or it is established to the satisfaction of a plan representative that such consent may not be obtained by reason of circumstances described in section 205(c)(2)(B) [29 USCS § 1055(c)(2)(B)]), or

(II) an election to waive the right of the spouse to a qualified joint and survivor annuity or a qualified preretirement survivor annuity is in effect in accordance with the requirements of section 205(c) [29 USCS § 1055(c)],

(ii) such spouse is ordered or required in such judgment, order, decree, or settlement to pay an amount to the plan in connection with a violation of part 4 of this subtitle [29 USCS §§ 1101 et seq.], or

(iii) in such judgment, order, decree, or settlement, such spouse retains the right to receive the survivor annuity under a qualified joint and survivor

annuity provided pursuant to section 205(a)(1) [29 USCS § 1055(a)(1)] and under a qualified preretirement survivor annuity provided pursuant to section 205(a)(2) [29 USCS § 1055(a)(2)], determined in accordance with paragraph (5).

A plan shall not be treated as failing to meet the requirements of section 205 [29 USCS § 1055] solely by reason of an offset under this paragraph.

(5) (A) The survivor annuity described in paragraph (4)(C)(iii) shall be determined as if --

(i) the participant terminated employment on the date of the offset,

(ii) there was no offset,

(iii) the plan permitted commencement of benefits only on or after normal retirement age,

(iv) the plan provided only the minimum-required qualified joint and survivor annuity, and

(v) the amount of the qualified preretirement survivor annuity under the plan is equal to the amount of the survivor annuity payable under the minimum-required qualified joint and survivor annuity.

(B) For purposes of this paragraph, the term "minimum-required qualified joint and survivor annuity" means the qualified joint and survivor annuity which is the actuarial equivalent of the participant's accrued benefit (within the meaning of section 3(23) [29

USCS § 1002(23)]) and under which the survivor annuity is 50 percent of the amount of the annuity which is payable during the joint lives of the participant and the spouse.

(e) Limitation on distributions other than life annuities paid by the plan.

(1) In general. Notwithstanding any other provision of this part, the fiduciary of a pension plan that is subject to the additional funding requirements of section 302(d) [29 USCS § 1082(d)] shall not permit a prohibited payment to be made from a plan during a period in which such plan has a liquidity shortfall (as defined in section 302(e)(5) [29 USCS § 1082(e)(5)]).

(2) Prohibited payment. For purposes of paragraph (1), the term "prohibited payment" means—

(A) any payment, in excess of the monthly amount paid under a single life annuity (plus any social security supplements described in the last sentence of section 204(b)(1)(G) [29 USCS § 1054(b)(1)(G)]), to a participant or beneficiary whose annuity starting date (as defined in section 205(h)(2) [29 USCS § 1055(h)(2)]), that occurs during the period referred to in paragraph (1),

(B) any payment for the purchase of an irrevocable commitment from an insurer to pay benefits, and

(C) any other payment specified by the Secretary of the Treasury by regulations.

(3) Period of shortfall. For purposes of this subsection, a plan has a liquidity shortfall during the period that there is an underpayment of an installment under section 302(e) [29 USCS § 1082(e)] by reason of paragraph (5)(A) thereof.

(4) Coordination with other provisions. Compliance with this subsection shall not constitute a violation of any other provision of this Act.

(f) Missing participants in terminated plans. In the case of a plan covered by title IV, the plan shall provide that, upon termination of the plan, benefits of missing participants shall be treated in accordance with section 4050 [29 USCS § 1350].

29 USCS § 1132

UNITED STATES CODE SERVICE
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*** CURRENT THROUGH P.L. 108-302, APPROVED 8/17/04 ***

TITLE 29. LABOR
CHAPTER 18. EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
PROTECTION OF EMPLOYEE BENEFIT RIGHTS
REGULATORY PROVISIONS
ADMINISTRATION AND ENFORCEMENT

29 USCS § 1132 (2004)

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 USCS § 1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection (c) or under subsection (i) or (I);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [29 USCS § 1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [29 USCS § 1021(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [29 USCS § 1021(f)],

or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an Individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of the Internal Revenue Code of 1986 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle [29 USCS §§ 1051 et seq., §§ 1081 et seq.] (relating to participation, vesting, and funding), only if –

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 515 [29 USCS § 1145].

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 [29 USCS §§ 1181 et seq.] against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 733(a)(1) [29 USCS § 1191b(a)(1)]). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) [Caution: For provisions applicable to plan years beginning on or before December 31, 2004, see note below describing amendment made to this paragraph by Act April 10, 2004.] Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606, section 101(e)(1), or section 101(f) [29 USCS § 1166(a)(1) or (4), § 1021(e)(1), or § 1021(f)] with respect to a participant or beneficiary, or (B) who fails or refuses

to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $ 100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(4) [29 USCS § 1021(b)(4)]. For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) [29 USCS § 1024(a)(4)] for failure to provide material information shall not be treated as having been filed with the Secretary.

(3)Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) [29 USCS § 1021(d)] with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) [29 USCS § 1021(e)(2)] with respect to any person or who fails to meet the requirements of section

302(d)(12)(E) [29 USCS § 1082(d)(12)(E)] with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 a day for each violation by any person of section 302(b)(7)(F)(vi) [29 USCS § 1082(b)(7)(F)(vi)].

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g) [29 USCS § 1021(g)].

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6) [29 USCS § 1024(a)(6)], the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $ 1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary may assess a civil penalty against a plan administrator of up to $100 a day from the date of the plan administrator's failure or refusal to provide notice to participants and beneficiaries in accordance with section 101(i) [29 USCS § 1021(i)]. For purposes of

this paragraph, each violation with respect to any single participant or beneficiary shall be treated as a separate violation.

(8) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act [42 USCS § 1320b-14(c)(8)].

(d) Status of employee benefit plan as entity.

(1) An employee benefit plan may sue or be sued under this title as an entity. Service of summons, subpoena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this title against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this title.

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 101(f)(l) [29 USCS § 1021(f)(1)]. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this title is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions.

(1) In any action under this title (other than an action described in paragraph 2) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

(2) In any action under this title by a fiduciary for or on behalf of a plan to enforce section 515 [29 USCS § 1145] in which a judgment in favor of the plan is awarded, the court shall award the plan–

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of–

(i) interest on the unpaid contributions, or

(ii) liquidated damages provided for under the plan in an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of the Internal Revenue Code of 1986 [26 USCS § 6621].

(h) Service upon Secretary of Labor and Secretary of the Treasury. A copy of the complaint in any action under this title by a participant, beneficiary, or fiduciary (other

than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle [29 USCS §§ 1101 et seq.]. If the Secretary brings an action under subsection (a) on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty. In the case of a transaction prohibited by section 406 [29 USCS § 1106] by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of the Internal Revenue Code of 1986 [26 USCS § 4975(f)(4)]) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of such Code [26 USCS § 4975(f)(5)]) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of such Code [26 USCS § 4975(e)(1)].

(j) Direction and control of litigation by Attorney General. In all civil actions under this title, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of title 28, United States Code), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor. Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this Act, or to compel him to take action required under this title, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries.

(1) In the case of—

(A) any breach of fiduciary responsibility under (or other violation of) part 4 [29 USCS §§ 1101 et seq.] by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount

which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1)--

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5).

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that—

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9)) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of the Internal Revenue Code of 1986 [26 USCS § 4975].

(m) Penalty for improper distribution. In the case of a distribution to a pension plan participant or beneficiary in violation of section 206(e) [29 USCS § 1056(e)] by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

COBRA CONTINUATION COVERAGE

This continuation only applies to health and dental coverage. Qualifying events (e.g., termination of the Participant's employment, reduction in hours worked by the Participant, death of the Participant, divorce or legal separation of the Participant, the Participant's entitlement to Medicare, or a Dependent Child who ceases to be an eligible dependent) are described herein. Additional extensions are available with multiple qualifying events (e.g., becoming divorced or legally separated while on regular 18-month continuation). If events are multiple, contact the Plan Supervisor.

CONVERSION OF MEDICAL BENEFITS

Conversion is not offered.

CERTAIN TERMS OR PHRASES

Employer (and Plan Sponsor) mean:

Employer Name: Horton Homes, Inc.

Address: 101 Industrial Boulevard
PO Drawer 4410

City, State, Zip: Eatonton, Georgia 31024

EIN: 58-1087227

Tel: (706)485-8506 **Fax:** (706)485-4446

Participating Employers means

American Testing Labs, Inc.
d.b.a. Horton Components Wholesale Distributors, Inc.
H&S Homes, L.L.C.

Plan Name means

The Health Care Plan of Horton Homes, Inc.

Plan Number for Administration Purposes is SF 564; H&S Homes, L.L.C. SF 630.

ERISA Plan Number is 502.

Effective Date of the Plan is January 1, 1996, amended and restated January 1, 1998.

Plan Supervisor means ACS Consulting Services, Inc. or its successor as may be appointed by the Employer.

Plan Administrator means the Employer. Plan Administrator is also the Named Fiduciary and Agent of Legal Service of Process. The Plan Administrator has the final authority and responsibility to review and make final decisions on Plan matters such as benefit adjudication, eligibility for coverage determinations, and construing terms.

Plan Coordinator means Rudy Hicks or a successor as shall be named by the Employer.

Type of Welfare Plan means health and dental.

Plan Trustees mean none. Plan is not trusteed.

Benefit Year means Calendar Year.

Plan Year means the twelve (12) month period from January 1 to January 1.

Employee means all full-time employees in Eligibility Class.

terms of the Plan. Based on this investigation and the information which the above-referenced Participant previously provided ACS, the Plan Administrator has made the following factual determinations:

1. On March 29, 1984, the Superior Court of Warren County Georgia entered an order requiring the Participant to pay child support for the Patient in the amount of $80 per month until the Patient became self-supporting, married, died, or became 18 years of age. A copy of that order is enclosed.

2. On or about September 22, 1999, prior to starting work for the Company, the Participant completed an Enrollment Form for medical and dental coverage under the Plan. On the Enrollment Form he listed the Patient as a "Dependent Child" along with four other minor children.

3. On September 26, 1999, the Patient began working for a Long John Silver's restaurant in Thomson, Georgia, earning $5.15 per hour. From that date through May, 2001, the Patient's earnings from Long John Silver's averaged more than $223 per month.

4. On September 27, 1999, the Participant began his employment with the Company.

5. Shortly after October 19, 1999, the Company received a Notice to Payor (the "Notice") from Child Support Enforcement ("CSE") directing the Company to begin deducting $90 per month from the Participant's earnings and to remit the same to CSE. The Notice indicated that of the $90 per month, $80 per month was for current child support and $10 per month was to catch up on previously owed support totaling $190.06. A copy of the Notice is enclosed.

6. Accompanying the Notice was a Consent income Deduction Order dated January 17, 1992, (the "Order") requiring the deductions that the Notice directed be made. A copy of this Consent Income Deduction Order is enclosed.

7. On November 5, 1999, pursuant to the Notice and Order, the Company began deducting from Mr. Franklin's paycheck and remitting to Child Support Enforcement the sum of $43.20 per pay period (there being 25 pay periods per year).

8. On June 8, 2001, the Patient was admitted to Doctors Hospital Augusta in Augusta, Georgia, as an emergency patient. She remained hospitalized there until her death on July 21,2001.

9. From prior to the date on which the Participant began working for the Company until her hospitalization on June 8, 2001, the Patient's lodging was provided

NOTICE TO FUNERAL DIRECTOR AND CERTIFYING PHYSICIAN

(1) WAS THIS DEATH THE RESULT OF VIOLENCE, SUICIDE, OR CASUALTY; (2) WAS THE DECEASED IN APPARENT GOOD HEALTH; (3) WAS THE DECEASED UNATTENDED BY A PHYSICIAN; OR (4) WAS ANY SUSPICIOUS OR UNUSUAL MANNER ASSOCIATED WITH THIS DEATH? ☐ YES ☐ NO
IF "YES" TO EITHER 1, 2, 3, OR 4, PLEASE NOTIFY THE CORONER IN THE COUNTY WHERE THE BODY WAS FOUND OR THE DEATH OCCURRED.

CERTIFICATE OF DEATH/STATE OF GEORGIA

DECEDENT'S NAME (First, Middle, Last)
Candace Autiel Murray

IF DECEDENT IS FEMALE, ENTER MAIDEN LAST NAME
Murray

SEX
Female

DATE OF DEATH (Mo., Day, Year)
July 21, 2001

RACE (White, Black, Amer. Indian, etc.) (Specify)
Black

ORIGIN OF DECEDENT (Italian, Mex., French, English, etc.)
American

DATE OF BIRTH (Mo., Day, Year)
Aug. 21, 1983

AGE - Last Birthday (Years)
17

UNDER 1 YEAR
Mos. ___ Days ___

UNDER 1 DAY
Hours ___ Mins. ___

COUNTY OF DEATH
Richmond

CITY, TOWN or LOCATION OF DEATH
Augusta

HOSPITAL OR OTHER INSTITUTION NAME (If not in either, give street and No.)
Doctors Hospital

IF HOSPITAL OR INST. (Indicate DOA, OP/EMER. Rm., Inpatient) (Specify)
Inpatient

STATE AND COUNTY OF BIRTH (If not in USA, name Country)
Ga - Richmond

CITIZEN OF WHAT COUNTRY?
USA

MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Never married

SPOUSE (If married or widowed, give spouse's name – if wife, give maiden name)
None

WAS DECEDENT EVER IN U.S. ARMED FORCES (Yes or No)
No

SOCIAL SECURITY NUMBER
258-47-2782

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cashier/Server

KIND OF INDUSTRY OR BUSINESS
Long John Silvers

RESIDENCE – STATE
Georgia

COUNTY
McDuffie

CITY, TOWN or LOCATION
Thompson

STREET AND NUMBER
850 Clements St. 30824

INSIDE CITY LIMITS? (Yes or No)
No

FATHER'S NAME
First Middle Last
Linton Franklin

MOTHER'S MAIDEN NAME
First Middle Last
Pamela Murray

INFORMANT'S NAME
First Middle Last
Pamela Murray

MAILING ADDRESS (Street, R.F.D. No., City or Town, State, Zip)
850 Clements St, Thomson, Ga. 30824

RELATIONSHIP
Mother

BURIAL, CREMATION, REMOVAL (Specify)
Burial

DISPOSITION DATE (Mo., Day, Year)
July 27, 2001

CEMETERY OR CREMATORY NAME
Jones Chapel C.M.E. Church

LOCATION (City or Town, State, Zip, County)
Thomson, Ga. 30824 McDuffie

FUNERAL DIRECTOR (Signature)
► /s/

FUN. DIR. LICENSE NO.
3155

NAME AND ADDRESS OF FACILITY (Street, R.F.D. No., City or Town, State, Zip)
Thomson Funeral System
536 M.L. KING, JR. ST.
Thomson, Georgia 30824

EST. LICENSE NO.
1169

EMBALMER (Signature)
► /s/

EMBALMER LICENSE NO.
2377

IMMEDIATE CAUSE
A. Severe adult respiratory distress syndrome

Due to, or as a consequence of:
B. Major puerperal infection, postpartum complication

Due to, or as a consequence of:
C. Necrotizing fasciitis

Approximate interval between onset and death
1 week

Approximate interval between onset and death
6 weeks

Approximate interval between onset and death
6 weeks

OTHER SIGNIFICANT CONDITIONS - conditions contributing to death but not related to cause given in Part IA. (If female, indicate if pregnant or birth occurred within 90 days of death)
1. C-section
2. History of asthma

AUTOPSY (Yes or No)
Yes

IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH? (Yes or No)
Yes

WAS OPERATION PERFORMED (Yes or No)
Yes

DATE OF OPERATION (Mo., Day, Year)
6/10/01, 6/20/01, 7/2/01

CONDITIONS FOR WHICH OPERATION WAS PERFORMED (Specify)
Excise dead skin, cover with homograft.

ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify)
Pregnancy, C-section

DATE OF INJURY (Mo, Day, Year)
5/31/01

DESCRIBE HOW INJURY OCCURRED
Infection from abdominal wound

HOUR OF INJURY
Unknown

INJURY AT WORK? (Yes or No)
No

PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify)
Doctors Hospital

LOCATION (Street, R.F.D. No., City or Town, State, Zip, County)
Augusta, Georgia

To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated

(Signature and Title)
► /s/

DATE SIGNED (Mo., Day, Year)
8/2/2001

HOUR OF DEATH
7/21/01 8:41 a.m.

NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER
Robert F. Mullins, M.D.

NAME, TITLE, AND LICENSE NO. OF CERTIFIER

(Physician, Medical Examiner, or Coroner)
Robert F. Mullins, M.D.

PHYS. LIC. NO.
049835

ADDRESS OF CERTIFIER (Street, R.F.D. No., City or Town, State, Zip)
1220 George C. Wilson Dr. Augusta, GA 30909

On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated
(Signature and Title)
▶

DATE SIGNED (Mo., Day, Year)

HOUR OF DEATH
8:41 a.m.

DATE PRONOUNCED DEAD (Mo., Day, Year)
HOUR PRONOUNCED DEAD

REGISTRAR (Signature)
▶

DATE RECEIVED BY REGISTRAR (Mo., Day, Year)

Ledger Report
MURRAY CANDACE A
Report Date: 10/18/2001

Claim Date	Service Date	Procedure		Responsible	Units	Insurance	Patient
Patient: MURRAY CANDACE A							
7/18/01	7/18/01	99231	Subsequent hospital care	ACS1	1	$67.00	
7/18/01	7/20/01	99231	Subsequent hospital care	ACS1	1	$67.00	
7/12/01	7/12/01	15852	DEBRIDEMENT OTHER THA	ACS1	1	$463.00	
7/9/01	7/9/01	15852	DEBRIDEMENT OTHER THA	ACS1	1	$139.00	
7/9/01	7/9/01	15852	DEBRIDEMENT OTHER THA	ACS1	1	$463.00	
7/6/01	7/6/01	15400	XENOGRAFT (PIGSKIN)	ACS1	1	$222.00	

7/6/01	7/6/01	15401	XENOGRAFT EACH ADD'L 10	ACS1	113	$8,781.00	
7/6/01	7/6/01	15400	XENOGRAFT (PIGSKIN)	ACS1	1	$740.00	
7/6/01	7/6/01	15401	XENOGRAFT EACH ADD'L 10	ACS1	113	$29,267.00	
7/4/01	7/4/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/4/01	7/7/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/4/01	7/8/01	99231	Subsequent hospital care	ACS1	1	$67.00	
7/4/01	7/16/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/3/01	7/3/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/3/01	7/6/01	99232	Subsequent hospital care	ACS1	1	$98.00	

November 9, 2001

PHYSICIANS MULTISPECIALTY
P 0 BOX 3726
AUGUSTA GA 30914

RE:	Health Care Plan:	Horton Homes, Inc.
	Employee:	Linton Franklin
	SSN:	252293946
	Claimant:	Candace Murray (deceased)
	Date(s) of Service:	6/10/01 to 7/20/01
	Amount Submitted:	$68,230.00

Dear Sir or Madam:

We have received the above claira(s) from you for services rendered to Candace Murray on the dates indicated. This letter represents a denial of those claims.

ACS Benefit Services, Inc. (ACS) is the third party administrator of the self-funded health care plan of Horton Homes, Inc. (the Plan). The Plan was established under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and is governed by that federal law. As set forth in the attached excerpt from the Plan Document, the Plan has specific criteria for determining who may be an eligible Dependent Child under the Plan. Among other factors, "The child must be principally dependent upon the Participant for financial support..."

7/3/01	7/11/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/3/01	7/12/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/3/01	7/13/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/3/01	7/14/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/2/01	7/2/01	16015	DEBRIDEMENT UNDER ANE	ACS1	1	$112.00	
7/2/01	7/2/01	15400	XENOGRAFT (PIGSKIN)	ACS1	1	$222.00	
7/2/01	7/2/01	15401	XENOGRAFT EACH ADD'L 10	ACS1	11	$855.00	
7/2/01	7/2/01	16015	DEBRIDEMENT UNDER ANE	ACS1	1	$372.00	
7/2/01	7/2/01	15400	XENOGRAFT (PIGSKIN)	ACS1	1	$740.00	

7/2/01	7/2/01	15401	XENOGRAFT EACH ADD'L 10	ACS1	11	$2,849.00	
7/1/01	7/1/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/1/01	7/2/01	99232	Subsequent hospital care	ACS1	1	$98.00	
7/1/01	7/10/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/28/01	6/28/01	99231	Subsequent hospital care	ACS1	1	$67.00	
6/28/01	6/30/01	99231	Subsequent hospital care	ACS1	1	$67.00	
6/24/01	6/24/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/24/01	6/25/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/24/01	6/26/01	99232	Subsequent hospital care	ACS1	1	$98.00	

Claim Date	Service Date	Procedure		Responsible	Units	Insurance	Patient
6/24/01	6/27/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/20/01	6/20/01	15000	EXCISIONAL PREP	ACS1	1	$195.00	
6/20/01	6/20/01	11042	EXCISION, SKIN & SUBCUTA	ACS1	1	$123.00	
6/20/01	6/2001	15350	APPLICATION OF ALLOGRAF	ACS1	1	$195.00	
6/20/01	6/20/01	15351	APPLICATION OF ALLOGRAF	ACS1	14	$1,244.00	
6/20/01	6/20/01	15000	EXCISIONAL PREP	ACS1	1	$648.00	
6/20/01	6/20/01	11042	EXCISION, SKIN & SUBCUTA	ACS1	1	$407.00	
6/20/01	6/20/01	15350	APPLICATION OF ALLOGRAF	ACS1	1	$648.00	

6/20/01	6/20/01	15351	APPLICATION OF ALLOGRAF	ACS1	14	$4,144.00	
6/16/01	6/16/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/13/01	6/13/01	20102	EXPLORATION OF THE ABD	ACS1	1	$295.00	
6/13/01	6/13/01	15000	EXCISIONAL PREP	ACS1	1	$195.00	
6/13/01	6/13/01	15001	EXC. PREP EACH ADD'L 100	ACS1	2	$200.00	
6/10/01	6/10/01	15000	EXCISIONAL PREP	ACS1	1	$195.00	
6/10/01	6/10/01	15001	EXC. PREP EACH ADD'L 100	ACS1	16	$1,599.00	
6/14/01	6/14/01	20102	EXPLORATION OF THE ABD	ACS1	1	$295.00	
6/14/01	6/14/01	11043	EXCISION, SKIN, SUBCU. TI	ACS1	1	$167.00	

6/14/01	6/14/01	20102	EXPLORATION OF THE ABD	ACS1	1	$981.00	
6/14/01	6/14/01	11043	EXCISION, SKIN, SUBCU. TI	ACS1	1	$555.00	
6/13/01	6/13/01	20102	EXPLORATION OF THE ABD	ACS1	1	$981.00	
6/13/01	6/13/01	15000	EXCISIONAL PREP	ACS1	1	$648.00	
6/13/01	6/13/01	15001	EXC. PREP EACH ADD'L 100	ACS1	2	$666.00	
6/10/01	6/10/01	15000	EXCISIONAL PREP	ACS1	1	$648.00	
6/10/01	6/10/01	15001	EXC. PREP EACH ADD'L 100	ACS1	16	$5,328.00	
6/10/01	6/10/01	99254	Initial In-Patient consul	ACS1	1	$255.00	
6/10/01	6/11/01	99232	Subsequent hospital care	ACS1	1	$98.00	

6/10/01	6/14/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/10/01	6/18/01	99232	Subsequent hospital care	ACS1	1	$98.00	
6/10/01	6/19/01	99231	Subsequent hospital care	ACS1	1	$98.00	

SubTotal	$68,230.00	0.00
Totals	$68,230.00	0.00

Our investigation has revealed that Candace Murray was not an eligible dependent child of Linton Franklin when your services were rendered because she was not principally dependent upon Mr. Franklin for financial support. Therefore, Candace Murray was not eligible for coverage under the Plan. As a result, your claim is excluded from coverage.

We are confident that we have sufficiently investigated this matter to determine that your claim is nol eligible for coverage under the Plan. However, should you have information proving that claimant was an eligible dependent as defined by the Plan when your services were rendered, you may request reconsideration of our decision by submitting this information to us within sixty (60) days. You also have the right to appeal our decision to the Plan Administrator within sixty (60) days, should you so desire.

Sincerely,

Kim Brewer
Vice President, Claims

KB/nw Enclosure

cc: Linton Franklin
Horton Homes, Inc.

ASSIGNMENT

By my signature below and as the mother, custodial parent, and executor of Candace Murray's estate, I hereby irrevocably assign to Physicians' Multispecialty Group the right to recovery benefits against The Health Care Plan of Horton Homes, Inc. to the extent of the amount of the bill for services rendered to my daughter, Candace Murray, by Physicians' Multispecialty Group. The intent of this assignment is so that Physicians' Multispecialty Group may pursue the plan for recovery of benefits which may be payable for services rendered to my daughter, Candace Murray, by Physicians' Multispecialty Group. In the event that benefits are payable under the terms of the plan for the services rendered by Physicians' Multispecialty Group to my daughter, Candace Murray, then I hereby direct that such benefits be paid directly to Physicians' Multispecialty Group in satisfaction of any claims which Physicians' Multispecialty Group may have against my daughter's estate to the extent that benefits may be payable and only for services rendered by Physicians' Multispecialty Group to my daughter, Candace Murray.

/s/Pamela Murray
Signature

Date: 7-18-03

OVERPAYMENTS

If a Covered Person has been paid benefits under this Plan that are in excess of the benefits that should have been paid, or which should not (under the provisions of the Plan) have been paid, the Plan Administrator may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Covered Person or other present or future amounts payable to such person, or recover such amount by any other legal method that the Plan Administrator, in its sole discretion, shall determine. Each Covered Person hereby authorizes the deduction of such excess" payment for such benefits or other present or future compensation payments.

CONSTRUCTION

This Plan shall be construed consistent with ERISA.

NO WAIVER OR ESTOPPEL

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

LIMITATION ON ACTIONS

No action at law or in equity shall be instituted to recover under this Plan prior to the expiration of ninety (90) days after a claim for benefit has been filed in accordance with the requirements of this Plan. Nor shall any such action be instituted at any time unless instituted within three (3) years after the expenses due to injury or sickness are incurred or are alleged to have incurred. Further, any limitation on actions regarding benefits shall be as provided in this Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for the service of legal process under the Plan is the Plan Administrator, or designee, except that, with respect to benefits, the Plan Supervisor, if any, may be the agent for the service of legal process. The Plan Supervisor shall promptly furnish the Plan Administrator a copy of any complaint, summons or similar documents and, if so directed by the Plan Administrator, shall assist in any applicable defense as directed by counsel to the Plan.

ASSIGNABILTY

Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kinds. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise

encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

4. It provides at least two operating rooms and at least one post-anesthesia recovery room. It is equipped to perform diagnostic x-ray and laboratory examinations and has the capability to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set and a blood bank or other blood supply.

5. It provides the full time services of one or more registered graduate nurses for patient care in the operating rooms and post-anesthesia recovery rooms. Also, there shall be one registered nurse for each post-anesthesia recovery room.

6. It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or who require post-operative confinement.

7. It maintains an adequate medical record for each patient; such records are to contain an admitting diagnosis, medical history, operative report and a discharge summary.

The terms ambulatory and outpatient are interchangeable.

AVERAGE SEMI-PRIVATE RATE

The term *Average Semi-Private Rate* means the standard semi-private rate in the hospital. If the hospital does not have a semi-private rate, the rate shall be paid as set forth in the Schedule of Benefits. If the hospital has several semi-private rates, the prevailing or the most common rate shall

be used. Semi-private accommodations are usually rooms with two or more beds.

BENEFICIARY

The term *Beneficiary* means the person or persons named to receive Plan benefits. For all benefits, the beneficiary is the Participant except if such benefits are assigned to a health care provider.

BENEFIT FUND

The term *Benefit Fund* shall mean the depository through which the Employer self-funds any Plan benefits. The benefit fund may or may not be governed by a trust and may be included as part of the Employer's general assets. If such deposited funds are not trusteed, or if they can be withdrawn without tax-consequences by the Employer, regardless of the form of depository (e.g., investment account) such funds are Employer funds and not Plan assets.

BENEFIT YEAR

The term *Benefit Year* means that twelve month period set forth in the Schedule of Benefits.